

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copy. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25713	REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
George M Melvin			A B E Y			9 23 84						7:45 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
M			W			MONTH DAY YEAR March 18, 1927			57			YRS.				
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.						Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
EASTON			EASTON Memorial Hospital			Welder										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland			Q.A.			Grasonville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			P. O. Box 121			21638	
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
Samuel H. Abey									Lillian Goslee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes			W.W.II			213-22-7301			Catherine H. Abey			same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u>																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple myocardial infarctions</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced coronary arteriosclerosis</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>12</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>above</u> , (I) (we) (did) (did not) view the body after death.																
19. The (name) (name) opinion death occurred on the date and hour and from the causes stated																
22b. SIGNATURE <u>E. C. H. Schmidt</u>			22c. DEGREE <u>M.D.</u>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>23 Sept 84</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 09/25/84			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery			23d. LOCATION CITY OR TOWN Easton			COUNTY Talbot		STATE MD		
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Chester MD 21619			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 28 1984			25b. REGISTRAR'S SIGNATURE <u>John Henderson Pendleton</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25714								
												REG. NO.								
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Howard			R			Andrew			September 7 1984			30	30	AM	30		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Male			Cauc.			Dec. 23, 1891			92			Talbot			U.S.A.			Talbot		
YRS.									MONTHS DAYS HOURS MIN											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
EASTON			Memorial Hospital			Farmer			Farm											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE								
Maryland			Talbot			Easton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.F.D. #2 Box 239 21601								
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE			LAST					
George W. Andrew						Susie E. Rice														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			21625			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			220-34-9715A			Clifford S. Andrew			R.F.D. #1 Box 87 Cordova, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Cerebrovascular accident														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(b)			Atherosclerotic cardiovascular disease														
(c)						Ostium wall carcinoma														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 9/15/84 to 9/19/84, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE			MD Coblley			DECEASED			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			9-9-84											
MD Coblley						Easton, Maryland 21601														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial			Sept. 10, 1984			Woodlawn Mem.			Park Easton Talbot Md.											
24. FUNERAL DIRECTOR NAME																				
Howard E. Michael, Jr.																				

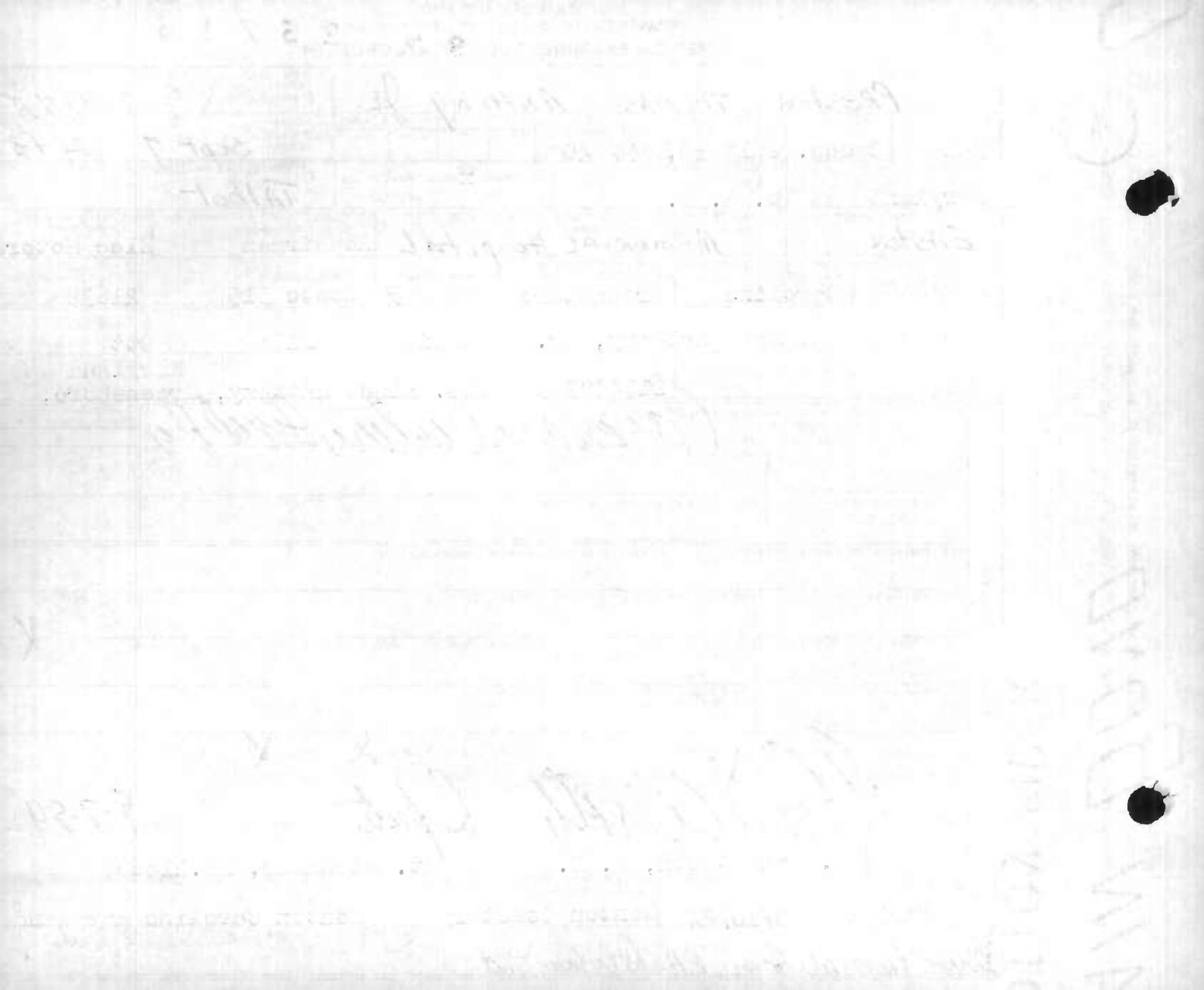


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5715

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN DEATH MATED	MONTH	DAY	YEAR	2b. HOUR 24 HOURS	
Preston Thomas Anthony Jr.						8/9/84	7	19	84	4:20 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD					
Male	Caucas.	July 30, 1941	40 yrs.			Sept 7	1984	4:35 PM			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U. S. A.							Talbot		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		Memorial Hospital			Repairman			Elec Motors			
13. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 313		21639	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Preston Thomas		Anthony		Sr.		Effie		Elda		Ott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes		213440383		Mrs. Diane Anthony, Greensboro		Maryland		Carryover from last entry			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE R. Lane Wroth, M. D.		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		St. Michaels, Md. 21663							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		9/10/84		Denton Cemetery		Denton		Caroline		Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REGD. IN REC'D. YEAR		25b. REGISTRAR'S SIGNATURE					
Moore Funeral Home, P.A. Denton, Md				Sept 11, 1984		Jane Johnson					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25/16	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Leila Margaretta Armstrong						9 9 84			9:25A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Caucasian		2 13 1885			99 YRS.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U.S.		Talbot							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Easton		Meridian Nursing Center-The Pines								Clerk(ret.)	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland		Queen Anne's		Centreville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			South Liberty Street, 21617	
14. FATHER'S NAME FIRST LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Marion Washington Armstrong		Elizabeth Dodd									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Cousin ADDRESS R.D. 2, Box 355							
No		214-03-1450		Mrs. Elizabeth D. Clark, Centreville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacillary pneumonia</u> APPROXIMATE TIME OF DEATH 21617 Days											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> 21617 Days											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>78</u> , to <u>9/9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Donald T. Lewers MD</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>9/11/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Donald T. Lewers MD</u>		22e. ADDRESS <u>243 Box 106 Easton, MD 21601</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Burial</u> <u>Sep. 11, 1984</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Chesterfield Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Centreville, Q.A. Co., Md.</u>					
24. FUNERAL DIRECTOR NAME <u>James H. Barton, Jr.</u>		ADDRESS <u>Barton Funeral Home, Centreville, Md. 21611</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 18 1984</u>							

A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or read "No" to question 18, state the cause of death as an injury, or other traumatic event. The medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						25717	
						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR	
THOMAS A. ARMSTRONG SR.			8-26-84			1055A	
3. SEX			4. RACE			5. DATE OF BIRTH	
M			BK			MONTH DAY YEAR MAY 10 1902	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			6. AGE (IN YEARS LAST BIRTHDAY)	
Md			USA			77 YRS.	
7. 10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			8. BALTIMORE CITY OR COUNTY OF DEATH	
EASTON			MEMORIAL HOSP.			TALBOT	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md		Caroline		Ridgely		14. STREET ADDRESS / ZIP CODE Ridgely Md 21660	
15. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
William Fauntleroy Armstrong						Julia <del>Armstrong</del> Wilkinson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
-			486-09-6324			Margaret M. Armstrong	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						19. APPROXIMATE INTERVAL BEFORE DEATH Months	
Carcinoma of the Lung Carcinoma of the Lung						months	
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		23. 23. 23. 23. 23. 23.	
22a. I certify that (1) (this hospital) attended the deceased from _____ to _____, that (2) (we) last saw the deceased alive on _____, 19_____, and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) (did) (did not) view the body after death.						22b. SIGNATURE Thomas W. Fauntleroy, M.D.	
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED 8-30-84	
22e. ADDRESS Thomas W. Fauntleroy, M.D.						23a. NAME OF CEMETERY OR CREMATORIAL CH. Crematory	
23a. BURIAL, CREMATION, REMOVAL 1984		23b. DATE 9-1-84		23c. NAME OF CEMETERY OR CREMATORIAL CH. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Fooks Mortuary						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 18 1984 John Davidson Pendleton	
413 Gay St. Denton, MD							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached from the burial-trunk panel. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, an other traumatic event, a medical examiner or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25118				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
Claude J. Bowdle, SR.						September 28/1984			12:00							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
Male		White		December 10, 1913			70 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Hurlock, Md.		U.S.A.					Talbot									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Easton		Memorial		Farmer			Farming									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Dorchester		Hurlock						RFD 1, Box 182 21643						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			17. INFORMANT			ADDRESS								
Edgar R. Bowdle		Maude Lord			Marie Bowdle, RFD 1, Box 182, Hurlock, Md.			21643								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			18. CAUSE OF DEATH (Enter only one cause per line. Item 18, Part 1, DEATH WAS CAUSED BY: PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (d)			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH								
No		215-07-9425														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Tarcinoma Colon - SP. Colon resection. -																
19a. DATE OF OPERATION 9/24/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tarcinoma Colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from <u>July 82</u> to <u>9/28/84</u> , that (1) <input type="checkbox"/> lost saw the deceased alive on <u>Sept 28 1984</u> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated (b) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Richard F. Manegold, M.D.		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/28/84								
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE		
Richard F. Manegold, M.D.		Easton, Md. 21601			Burial			Oct. 1, 1984			Unity Washington Cem.			Hurlock, Dorchester, Maryland		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Frampton Hawkins Funeral Home																
ADDRESS																
Federalsburg, Md.																

40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25719	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			LAST			2d. DATE OF DEATH			2b. HOUR		
EDWARD H. CALLAHAN						9-13-84			1045 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
male			Caucasian			MONTH DAY YEAR			7E UNDER 1 YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MONTH DAYS HOURS MIN.		
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			YRS		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
EASTON			MEMORIAL HOSPITAL			TALBOT			MD.		
13. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland			Talbot			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			37 Mt. Pleasant Ave. /21601		
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS		
E. Harmond Callahan						Artie Elizabeth Roe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNEANT LYMPHOMA</u>		
YES			W W II			Eugenia E. Callahan see 13e.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 MO		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNEANT LYMPHOMA</u>			18b. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			18c. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>9-13</u> 1984 to <u>9-13</u> 1984, that (I) (we) last saw the deceased alive on <u>9-13</u> 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen P. Carney, M.D.</u>			DEGREE			22c. DATE SIGNED <u>9/14/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Stephen P. Carney, M.D.			Easton, Md. 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			9-15-84			Spring Hill Cemetery			Easton Talbot Md.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Newnam Funeral Home						SEP 18 1984			<u>Julia Davidson Pendall</u>		

PSI 88-81-9

7000 ft

10000 ft - 10000 ft - 10000 ft

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, in page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified or called.

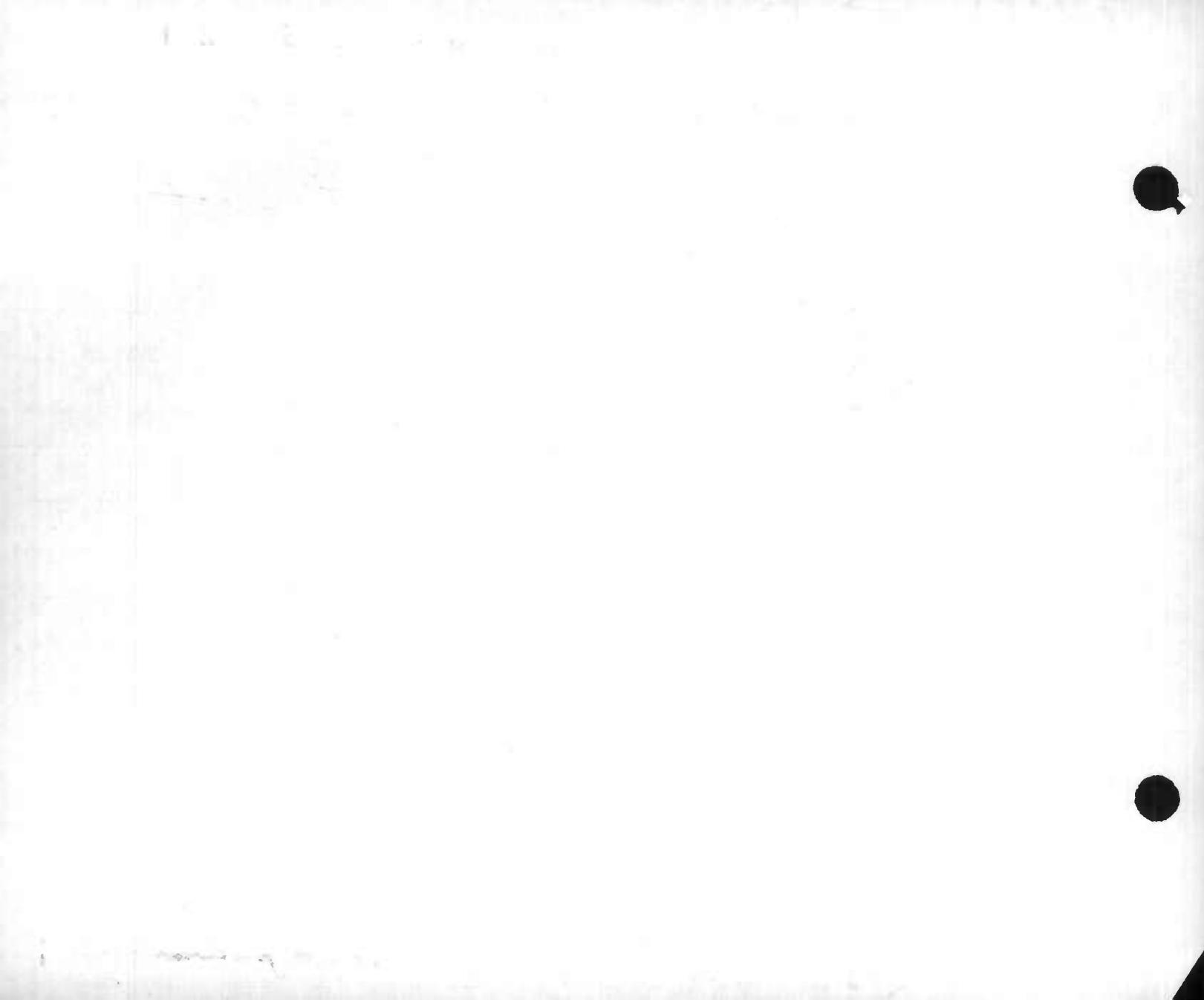
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25120			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
John			R	Carter		9-19-84					84	10:12 A			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		B1K		MONTH	DAY	YEAR	78			MONTHS	DAYS	HOURS	MIN.		
5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Md		USA					Talbot								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton		Memorial Hospital at Easton		Laborer											
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Md 8A Steeleville												YES <input type="checkbox"/> NO <input type="checkbox"/>		Route #3 Bay 64	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			16. ADDRESS			LAST					
James		Carter		Charles E. Carter						Hedrick					
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17c. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		217-28-4730					Brain-Stem Stroke								
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Insufficiency															
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE															
22c. DEGREE															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED					
Edmond Fitzgerald, M.D.		Easton, MD 21601													
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE		
Interred		9/24/84		Steeleville Cem.			Steeleville		8A		St. Marys		Md		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REC'D. DIRECTOR'S SIGNATURE								
George Daniel		Easton Md		SEP 21 1984			Julie Anderson, Director								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please  
retain by the hospital or attending physician.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25721					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Columbus Castle									8-13-84	8	13	84	5 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 1 HRS			
Male		BLK		7 24 09			75			YEARS	MONTHS	WEEKS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Md		USA					Talbot								
10. CITY OR TOWN OF DEATH		11a. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton		Memorial		Laborer											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		ZIP CODE			
Md		Talbot		Bellevue						R. I. Box 94		21654			
14. FATHER'S NAME		FIRST		LAST			15. MOTHER'S MAIDEN NAME			LAST					
Ben				Castle			Bertha			Bouldin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS					
No							Coronary artery Disease								
DUE TO, OR AS A CONSEQUENCE OF (b)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Previously dx Pre Zlevademia ; CVA															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-13-84 to 8-13-84, that (I) (we) last saw the deceased alive on 8-13-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I was (we) did not view the body after death.)															
22b. SIGNATURE Detrich, N.										DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Terry Detrich, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. ADDRESS Easton, Md. 21601										22c. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Richardson			23d. LOCATION CITY OR TOWN Easton			STATE Md.					
Burial		8/17/84													
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
George A. Dashiell		21601			Sep 28 1984			George A. Dashiell							



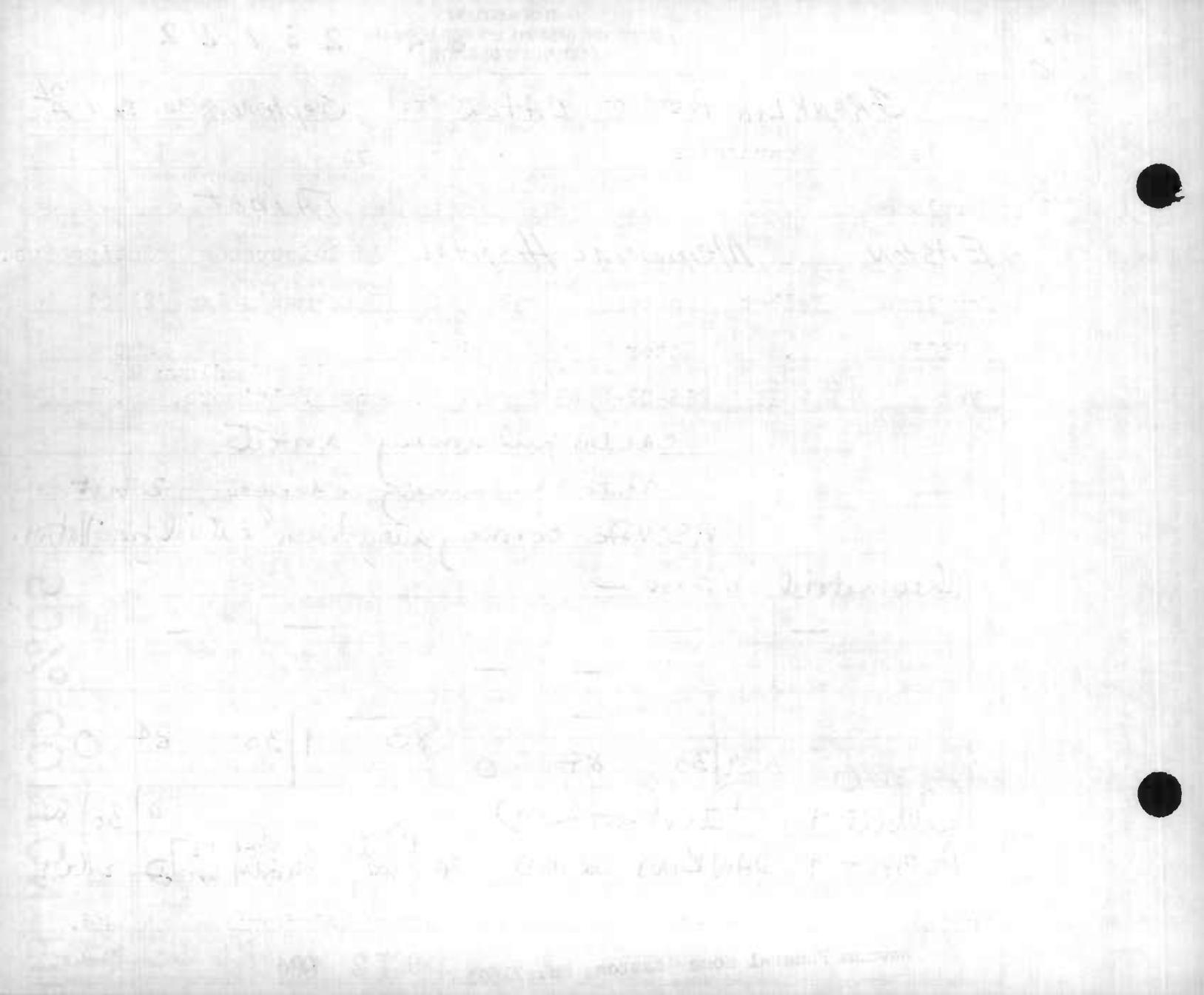
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25722				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
FRANKLIN Pattison CATOR Jr.						September 30 1984			101					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
male		caucasian		9 26 10			74							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			TA/bot				
Maryland		USA												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT MEDICAL FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton		Memorial Hosp. tal					Administrator			Printing Bus.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Talbot		Easton						Dutchman's Lane/21601				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
William W. Cator		Mabel			Bent									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS							
Yes		W W II		215-07-8283			Agness F. Bond			105 Woodlawn Rd. Baltimore, Md. 21210				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute pulmonary edema</u> 2 hrs.														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD coronary artery disease and atrial fibrillation.</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Rheumatoid disease</u> —														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>9/30/84</u> to <u>9/30/84</u> , that (I) (we) last saw the deceased alive on <u>9/30/84</u> and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated —														
22b. DEGREE ALBERT T. DAWKINS JR. M.D.		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/30/84									
22e. ADDRESS Newnam Funeral Home		22f. ADDRESS Easton, Md. 21601												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-2-84			23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery			23d. LOCATION CITY OR TOWN Baltimore			23e. COUNTY Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 2 1984			25b. REGISTRAR'S SIGNATURE Julia Dawson-Randall						



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Name 2 is marked or if Name 16 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25723					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
John F. Challenger												9-5-84				5:45 P	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
Male			Caucasian			5 23 1897			87			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Pennsylvania			USA						Talbot								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton			William Hill Health Care Center						Elec. Engineer								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Talbot			Easton						501 E. Dutchman's Lane/21601					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
J. Franklin			Challenger						Helen			Tyson			Rice		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES			159-09-1641			Dorothy B. Challenger see 13e'						3 weeks					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			Atherosclerotic cardiovascular disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE M D Crowley			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-6-84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M D Crowley			22e. ADDRESS Easton, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-8-84			23c. NAME OF CEMETERY OR CREMATORIAL All Saints Epis. Ceme.			23d. LOCATION CITY OR TOWN Rehobeth Beach Sussex Del.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME Newnam Funeral Home, P.A. Easton, Md.									25a. DATE REC'D. BY REGISTRAR SEP 10 1984			25b. REGISTRAR'S SIGNATURE Julia Dawson-Randall					



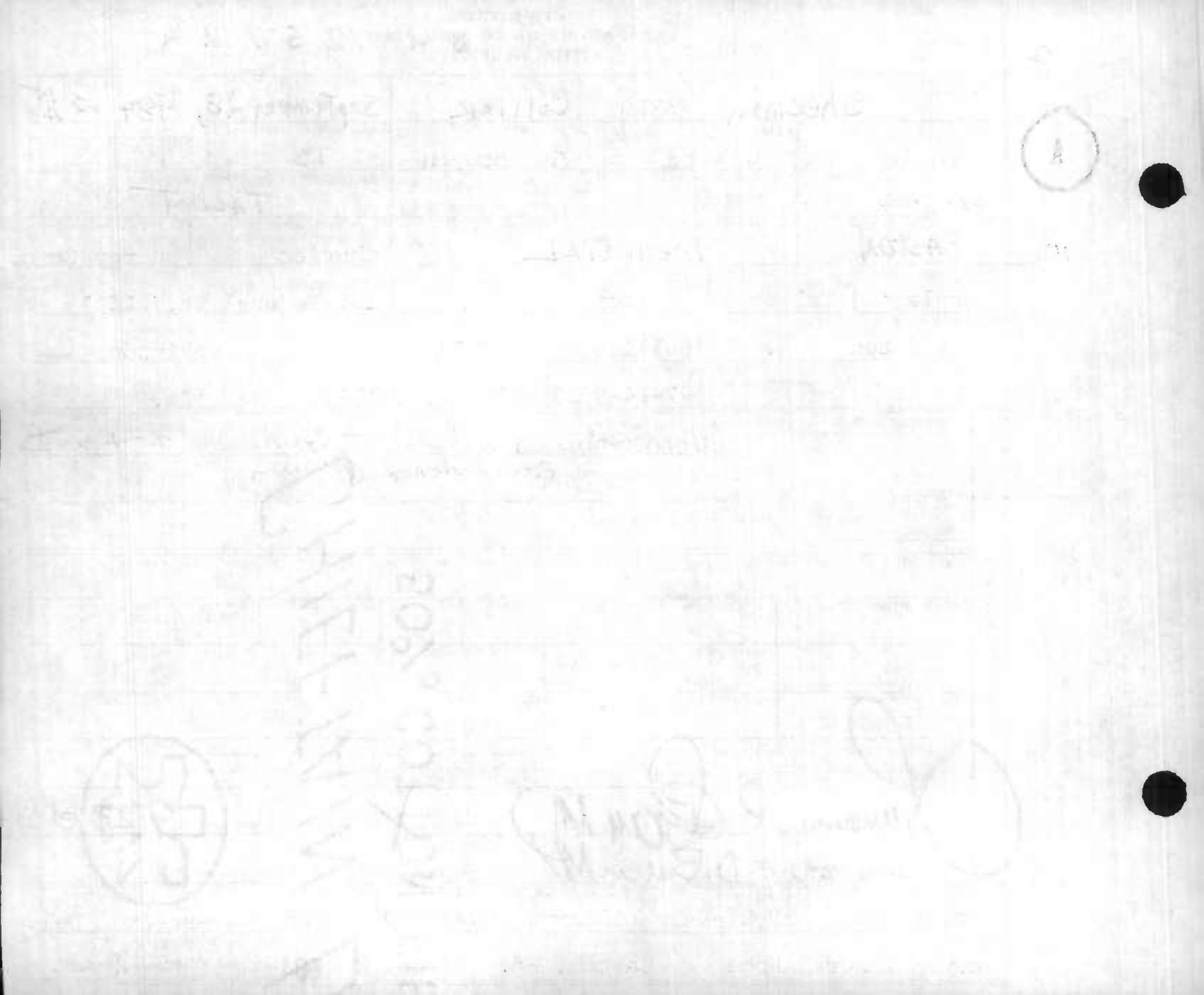
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 23 is checked, any injury, or other traumatic event, the medical

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH25724  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Sherman TAYLOR Collier						September 28, 1984				2:15 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		MONTH 5 DAY 05 YEAR 11			73 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
New York		USA					Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
EASTON		MEMORIAL		Courier			Energy Comm.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Maryland	Talbot		Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			201 Federal St./21601					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			ADDRESS						
Clinton E. Collier				Julia			Robinson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO		097-14-9653		Hilda E. Collier			see 13e.			2-7 months			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abnormal carcinoma metastasized to bone marrow</u>													
DUE TO, OR AS A CONSEQUENCE OF <u>from unknown primary</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Lawrence D. Bolen MD</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-28-84								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence D. Bolen MD		22f. ADDRESS Dutchman's Lane, Easton Md.											
23a. BURIAL, CREMATION, REMOVAL SPECIFY Cremation		23b. DATE 9-28-84		23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes		23e. COUNTY Sussex		23f. STATE Del.		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR OCT 2 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Filing &amp; may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 is checked, any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25725						
												REG. NO.						
1 - STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR						
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH	DAY	YEAR	40			
Edna			CARRIE			Cooper						9	30	84	6pm			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 2 YEARS				
Female			NEGRO			MONTH JULY DAY 4, 1908			76			MONTHS	YEARS	MONTHS	YEARS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
MARYLAND			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Easton			Memorial Hospital			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STREET ADDRESS / ZIP CODE			21656						
13a. STATE MARYLAND			13b. COUNTY A.			13c. CITY OR TOWN PRICE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
14. FATHER'S NAME JOSEPH			15. MOTHER'S MAIDEN NAME ROSIE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 219-07-6678			17. INFORMANT ADDRESS John JARRELL (BROTHER)			SAWER WILM. Det.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infected dialysis shunt</u>			DUE TO, OR AS A CONSEQUENCE OF (c)						8 days						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Chronic Renal Failure,																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9-30-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
Lawrence Bohan, M.D.																		
23a. BURIAL, CREMATION, REMOVAL LIPCFY			23b. DATE 10-5-84			23c. NAME OF CEMETERY OR CREMATORIAL ROSEVILLE CEM.			23d. LOCATION CITY OR TOWN PRICE			COUNTY Q.A.		STATE MD				
24. FUNERAL DIRECTOR NAME Fellows Funeral Home			ADDRESS Millington, Md.			25a. DATE REC'D. BY REGISTRAR 21651 OCT 5 1984			25b. REGISTRAR'S SIGNATURE Julia Deirdre Rydell									



Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or 18 shows any injury, or other traumatic event, a medical examiner should be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25126					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Thomas			D'Armi			September 9 1984			305 A.M.						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male		White		May 9, 1901			83 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Italy		U.S.A.					Talbot								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton		Memorial Hospital					Shoe Maker			Shoe Store					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE					
13b. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			203 Maple Avenue 21632					
14. FATHER'S NAME FIRST James D'Armi		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST Gertrude			16. SOCIAL SECURITY NO. 213-22-9104			17. INFORMANT ADDRESS Mrs. Sadie D'Armi, 203 Maple Ave., Md. 21632					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute					
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive lung disease										year					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Subdural Hematoma - May 85															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) not view the body after death.										22c. DATE SIGNED 9/10/84					
22b. SIGNATURE P. Gregg Rhodes MD										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Gregg Rhodes MD										22e. ADDRESS 593 Dutchman's Ln, Easton, Md 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN Federalsburg, Caroline, Md.								
Burial		Sept. 12, 1984		Hillcrest Cemetery											
24. FUNERAL DIRECTOR NAME Flempton - Hawkins		ADDRESS Box 45 Federalsburg		25a. DATE REC'D. BY REGISTRAR SEP 30 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson - Pendleton								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25727					
												REG. NO.					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Ruth N. Derrickson						9 20 84					9-20-84	8:35 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
female			Caucasian			8 28 06			78			MONTHS	YEARS	MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			TA1BOT MD.					
Maryland			USA														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton			Wm. Hill Manor			Supervisor			Telephone Co								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland		Talbot		Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			501 E. Dutchman's Lane			21601					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
James			Frank			Smith			Sarah			Wilhelmina			Blann		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			577-01-1677			Alfred L. Smith			Cardiac Arrest			AT LEAST 24 HRS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF (b)			ISCHEMIC CARDIOMYOPATHY			AT LEAST 24 HRS					
			(c)			DUE TO, OR AS A CONSEQUENCE OF (c)			PREVIOUS HEART ATTACKS.			" "					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>September 20, 1984</u> to <u>September 21, 1984</u> , that (I) (we) last saw the deceased alive on <u>Sept. 17, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and did not) view the body after death.																	
22b. SIGNATURE Scott D. Friedman MS			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-20-84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 403 MARVEL CT EASTON														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-22-84			23c. NAME OF CEMETERY OR CREMATORIAL Mariners Bethel			23d. LOCATION CITY OR TOWN Ocean View			COUNTY Sussex			STATE Del.		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR SEP 24 1984			25b. REGISTRAR'S SIGNATURE John Davidson Rendell								



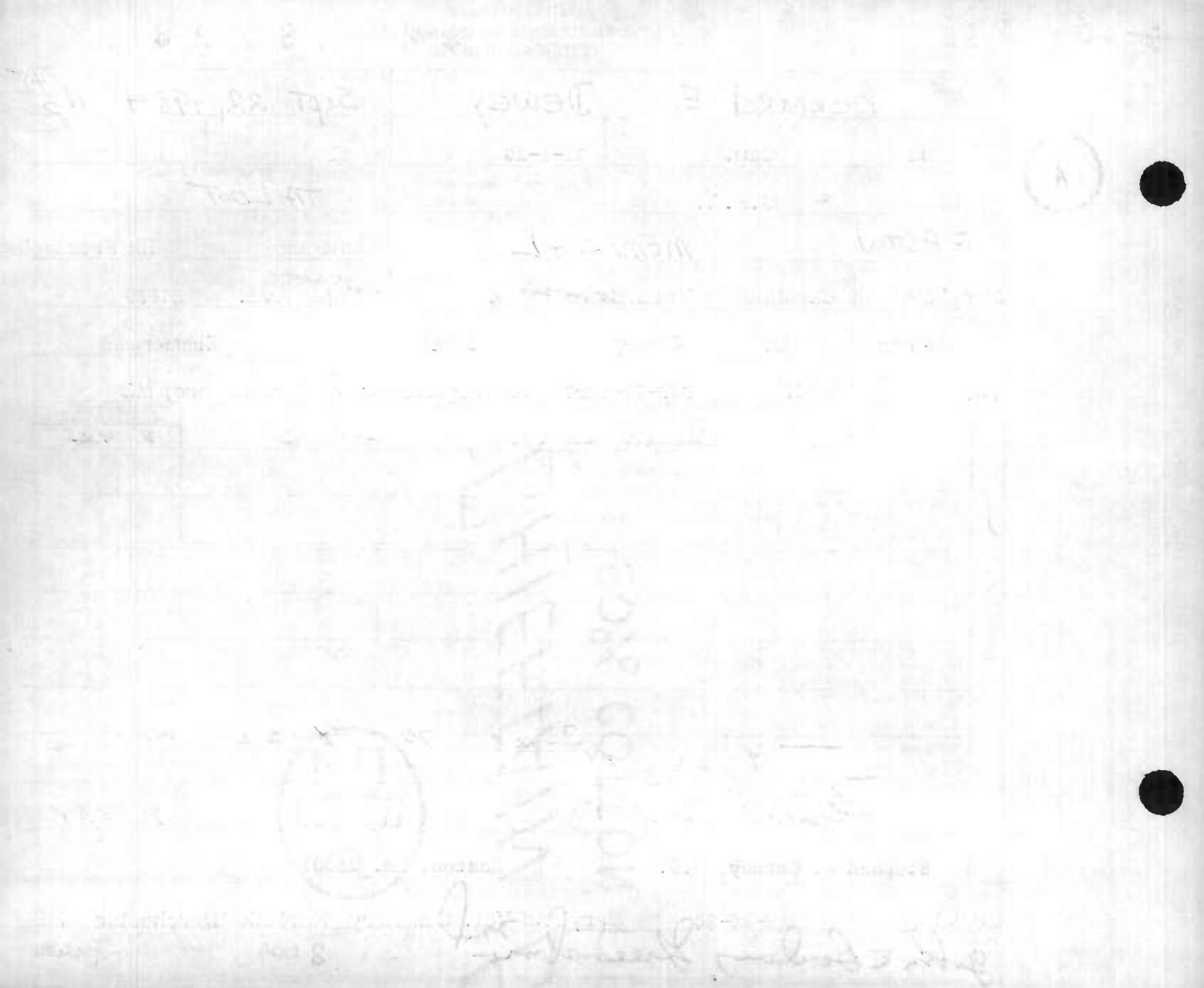
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25128	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Bernard E. Dewey			Dewey			Sept. 22, 1984			45		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR	
male		Cau.		12-5-20			63			11 PM	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Ohio		U.S.A.					Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
EASTON		Memorial		Manager			Milk Processing				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland		Caroline		Greensboro			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Maple Ave. 21639	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
George D. Dewey		Ethel			Zimmerman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
Yes		WWII		369-14-1090			Audreymae Dewey Greensboro, MD				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lymphocytic leukemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the physician) attended the deceased from <u>3-25</u> , 19 <u>84</u> , to <u>8-22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9-22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen P. Carney</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>9-23-84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Stephen P. Carney, M.D.		Easton, Md. 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-26-84		23c. NAME OF CEMETERY OR Crematory Maryland Vet. Cemetery			23d. LOCATION CITY OR TOWN Hurlock			STATE Dorchester	
24. FUNERAL DIRECTOR <u>John E. Bolding</u>		25a. DATE REC'D. BY REGISTRAR 2-19-84		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Pandell</u>							
BP _____											
DHMH - 16 50M 4/83 (VRA 15, 4)											



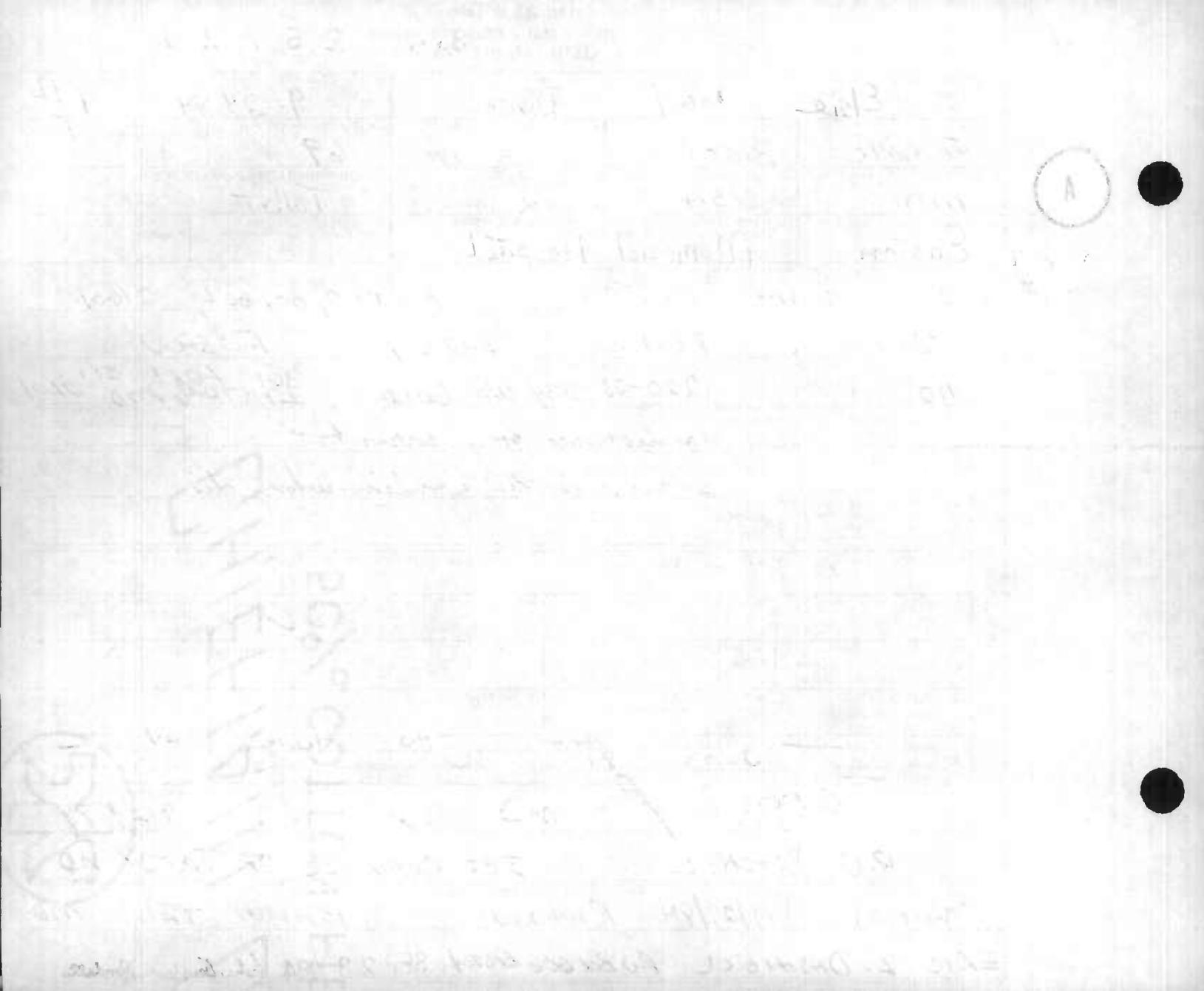
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25729		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	24. HOUR		
Elsie			MAY		Dixon	9-24-84						149 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Black		MONTH	DAY	YEAR	69			MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MD.		USA		8						Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton		Memorial Hospital												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
MD		Talbot		EASTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 7, Box 604, 21601						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT				
		John		Foster	Lizzy		NO			Wm. Gardner				
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY:		ADDRESS 301 Port St., EASTON, MD. 21601												
IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		cardiopulmonary arrest												
(b)		DUE TO, OR AS A CONSEQUENCE OF arterioclerotic cardiovascular dis-												
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <u>Sept</u> , 19 <u>80</u> , to <u>June</u> , 19 <u>84</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>June</u> , 19 <u>84</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <i>R. B. Sanchez</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9-24-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. B. Sanchez		22e. ADDRESS 322 Commerce Dr, EASTON MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/29/84		23c. NAME OF CEMETERY OR CREMATORIAL Richards			23d. LOCATION CITY OR TOWN EASTON		COUNTY TALBOT		MD.			
24. FUNERAL DIRECTOR NAME ERIC L. DASHIELL		ADDRESS P.O. Box 606 EASTON			25a. DATE REC'D. BY REGISTRAR SEP 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell							



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25130	
1. DECEASED NAME (TYPE OR PRINT)				2. DATE OF DEATH				3. HOUR			
FIRST John MIDDLE Plummer LAST EDMONSTON				9-15-84				640 P.M.			
4. SEX		5. RACE		6. DATE OF BIRTH		7. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS	
Male		White		January 14, 1910		74		MONTHS DAYS		HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		TALBOT		Salesman (retired) Furniture			
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
EASTON		MEMORIAL HOSPITAL						12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. Maryland		13b. Queen Anne's		13c. Centreville		13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. R.D. 2, Box 71H, 21617			
14. FATHER'S NAME		15. MOTHER'S MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		18. APPROXIMATE AGE AT DEATH BETWEEN CERTAIN AND EXACT			
FIRST Walter MIDDLE Cleveland LAST Edmonston		FIRST Mary MIDDLE Emma LAST Cumberland		16a. (IF YES, GIVE WAR OR DATES)		17. Wife		18. R.D. 2, Box 71H			
16b. No		16c. 214-12-0542		17. Mrs. Beulah D. Edmonston, Centreville, Md.		18. 21617					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory failure						8 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)		DUE TO, OR AS A CONSEQUENCE OF CHRONIC OBSTRUCTIVE LUNG DISEASE						20 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
19a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20b. YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		21c. ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (he/she) attended the deceased from 5-10, 1978, to 9-15, 1984, that (1) (he/she) last saw the deceased alive on 9-15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above). (1) (he/she) (did not) view the body after death.											
22b. SIGNATURE Stephen P. Carney, M.D.		22c. DEGREE						22d. DATE SIGNED 9-16-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Stephen P. Carney, M.D.		Easton, Md. 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY			
Burial		Sep. 18, 1984		Woodlawn Memorial Park		Easton		23e. STATE Talbot, Md.			
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
James H. Barton, Jr.		SEP 20 1984						Barton, Md.			
Barton Funeral Home		Centreville, Md.									



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 7 3 1  
REG. NO.

1- STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED X 9 13 84 130 PM												2b. HOUR 28. HOUR 130 PM					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST											
HAROLD			MEDVIN			ENGLISH														
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			9. DATE MONTH DAY YEAR BALTIMORE CITY OR COUNTY OF DEATH			
male		Caucasian		5 20 23			61 YRS.							9 13 84 22 PM			Talbot			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>														
West Virginia			USA															MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton			Rt. 1 Box 110, Easton, Md.									Doctor			Medical					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21601					
Maryland			Talbot			Easton						Rt 1 Box 110, Easton, Md.								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Harold			Chancellor			English			Sara			Kathryn			Bowers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
yes			220-18-2309			Patricia D. English						Rt. 1 Box 110 Easton, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Nangang</i> DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																				
(b) DUE TO, OR AS A CONSEQUENCE OF																				
(c) DUE TO, OR AS A CONSEQUENCE OF																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									19c. AUTOPSY?								
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 10 9 13 84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Self Duplicell</i>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY STREET, FACTORY, FARM, ETC. <i>Home</i>			21f. LOCATION STREET, CITY, TOWN <i>East Pt Rd.</i>			21g. CITY OR TOWN <i>12604 Co. Md.</i>											
22a. I certify that a full <u>copy</u> of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <input type="checkbox"/> Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <i>R. Lane Wroth</i>															DATE SIGNED <i>9/14/84</i>					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			St. Michaels, Md. 21663														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE					
Cremation			9-14-84			Delmarva Crematory			Lewes			Sussex			Del.					
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Newnam Funeral Home			Easton, Md.						SEP 18 1984			June L. Wroth								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR USE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25132				
1. DECEASED NAME											REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
CHARLES			Donalson			FAIRBANK						9	4	84		11A 20
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White			Month Day Year						79	YRS.		MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U.S.A.			Jan 14, 1905						TALBOT MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY				
Easton			EASTON MEMORIAL Hospital			St. Hgwy Administration										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland			Q.A.			Stevensville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			P. O. Box 12			21666	
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME							
Howard Fairbank									Rosa Coleman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1. DEATH WAS CAUSED BY			ADDRESS				
No			214-32-1446			Mary E. Fairbank										
IMMEDIATE CAUSE (a)			bend fairbank													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) arterio sclerosis													
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (will) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
James Gieske, M.D.												Sep 13 1984				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burila			09/07/84			Stevensville Ceme.			Stevensville			Q.A.		MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Tom Helfenbein Funeral Home			21619, Md.			Sep 13 1984			John Davidson - Pendell							

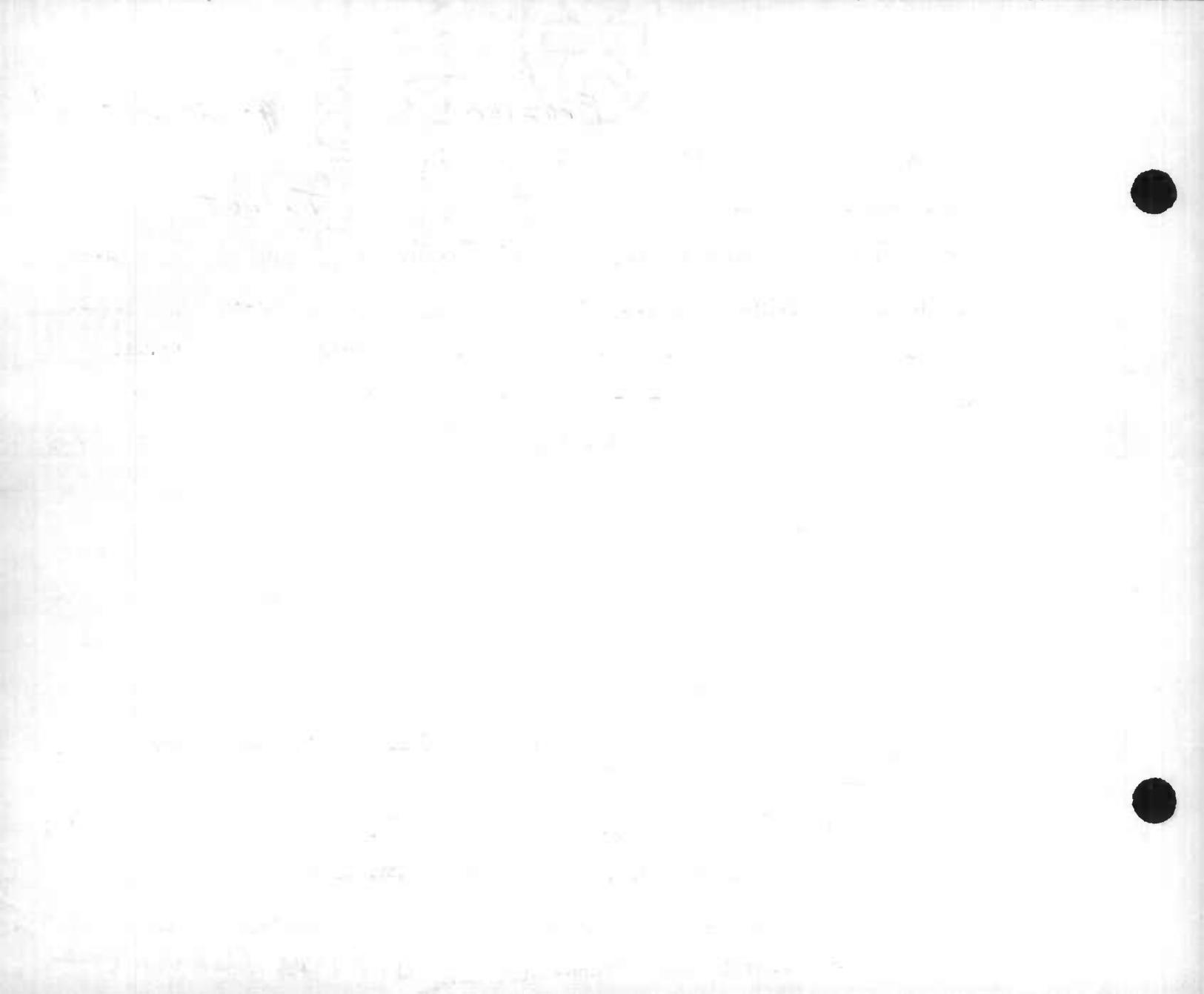


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						25733
						REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR
Dorothy Jeannette Frazier			9-12-84			5:16 AM
3. SEX			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)
Female			7 9 32			52
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Pennsylvania			USA			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife
13a. STATE Maryland			13b. COUNTY Caroline			12b. KIND OF BUSINESS OR INDUSTRY Home
14. FATHER'S NAME Foster			15. MOTHER'S MAIDEN NAME Hickey D. Pearl			16. ADDRESS N. Main Street 21639
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-28-0963			17. INFORMANT Nelson Frazier
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BREAST CANCER						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 yrs
DUE TO, OR AS A CONSEQUENCE OF (b)						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		
22a. I certify that (I) (this hospital) attended the deceased from 9/11/84 to 9/12/84, that (I) (we) last saw the deceased alive on 9/11/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22b. SIGNATURE Stephen P. Carney, M.D.		DEGREE		22c. DATE SIGNED 9/15/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Easton, Md. 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-84		23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery		23d. LOCATION CITY OR TOWN Greensboro COUNTY CA STATE MD
24. FUNERAL DIRECTOR NAME Boulais Funeral Home		ADDRESS Greensboro, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 24 1984 Julie L. Johnson-Randall		



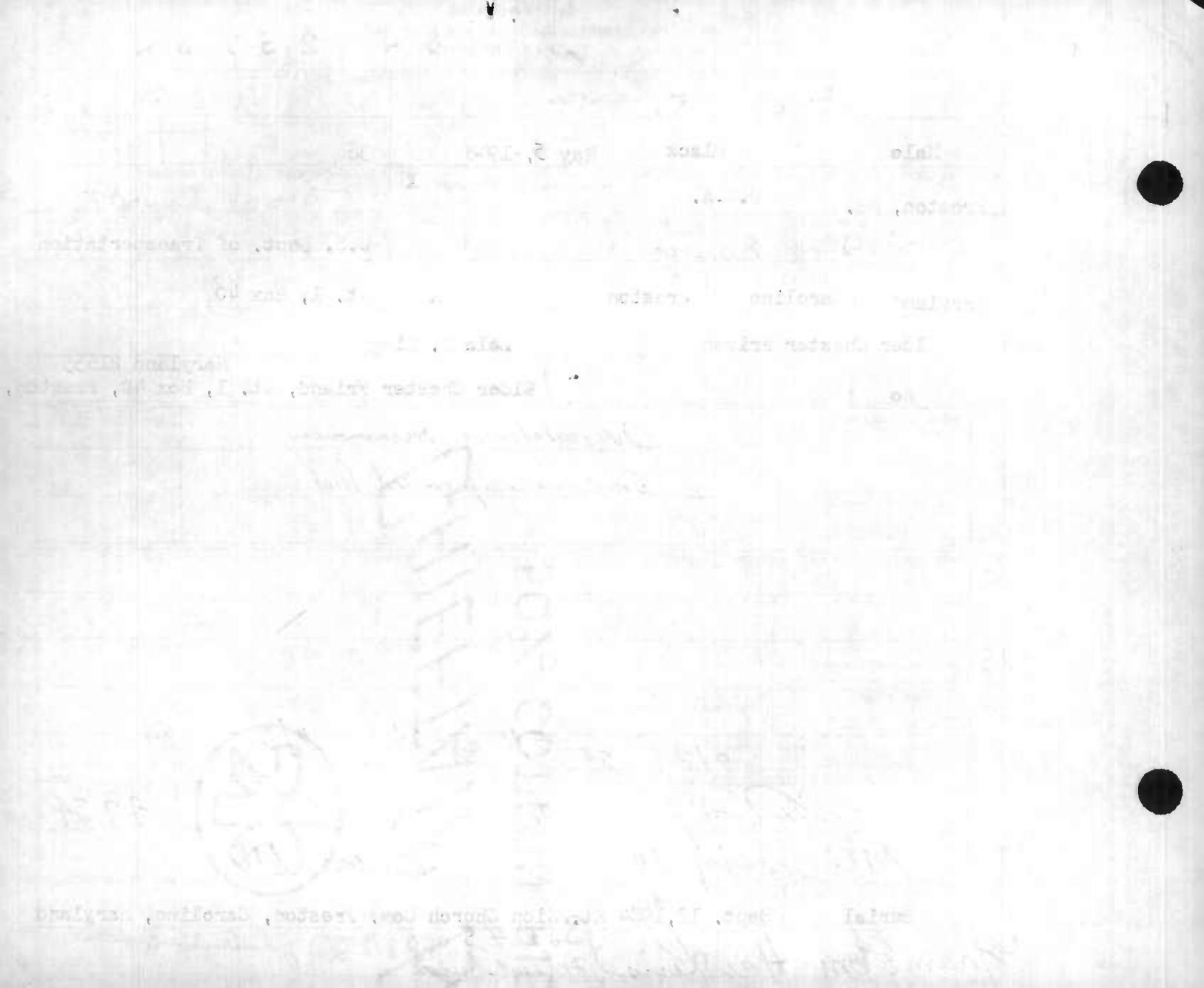
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												4	25134 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Samuel D. Friend												9 8 84						6:52 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS				
Male			Black			MONTH DAY YEAR			36			MONTHS DAYS			HOURS MIN.				
7. BIRTHPLACE (COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. DATE OF BIRTH			10. AGE (IN YEARS LAST BIRTHDAY)			11. BALTIMORE CITY OR COUNTY OF DEATH			12. IF UNDER 1 YEAR				
Preston, Md.			U.S.A.			May 5, 1948			36			Talbot County			MONTHS DAYS				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Easton			Easton Memorial			U.S. Dept. of Transportation						21655							
13. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION			13a. INSIDE CITY LIMITS?			13b. STREET ADDRESS / ZIP CODE													
13. STATE Maryland			13a. COUNTY Caroline			13b. CITY OR TOWN Preston			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1, Box 40							
14. FATHER'S NAME FIRST Elder Chester Friend			15. MOTHER'S MAIDEN NAME FIRST Lela M. King																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
No						Elder Chester Friend, Rt. 1, Box 40, Preston,			Maryland 21655										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c). PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE 1a) Overwhelming pneumonia																			
DUE TO, OR AS A CONSEQUENCE OF (b) Immune compromised host																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/18/84 to 9/18/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE MD Crowley MD.			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9.9.84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Zion Church Cem.			23d. LOCATION CITY OR TOWN Preston, Caroline, Maryland				
Burial			Sept. 12 1984			Box 45			23d. LOCATION CITY OR TOWN Preston, Caroline, Maryland										
24. FUNERAL DIRECTOR NAME Franklin - Hawkins			ADDRESS Federalburg			24. DATE SIGNED SEPT 14 1984			24. REGISTERED BY REG. NO. J. Johnson			24. REGISTRAR'S SIGNATURE							
BP																			
DHMH - 16 50M 4/83 (VRA 15, 4)																			



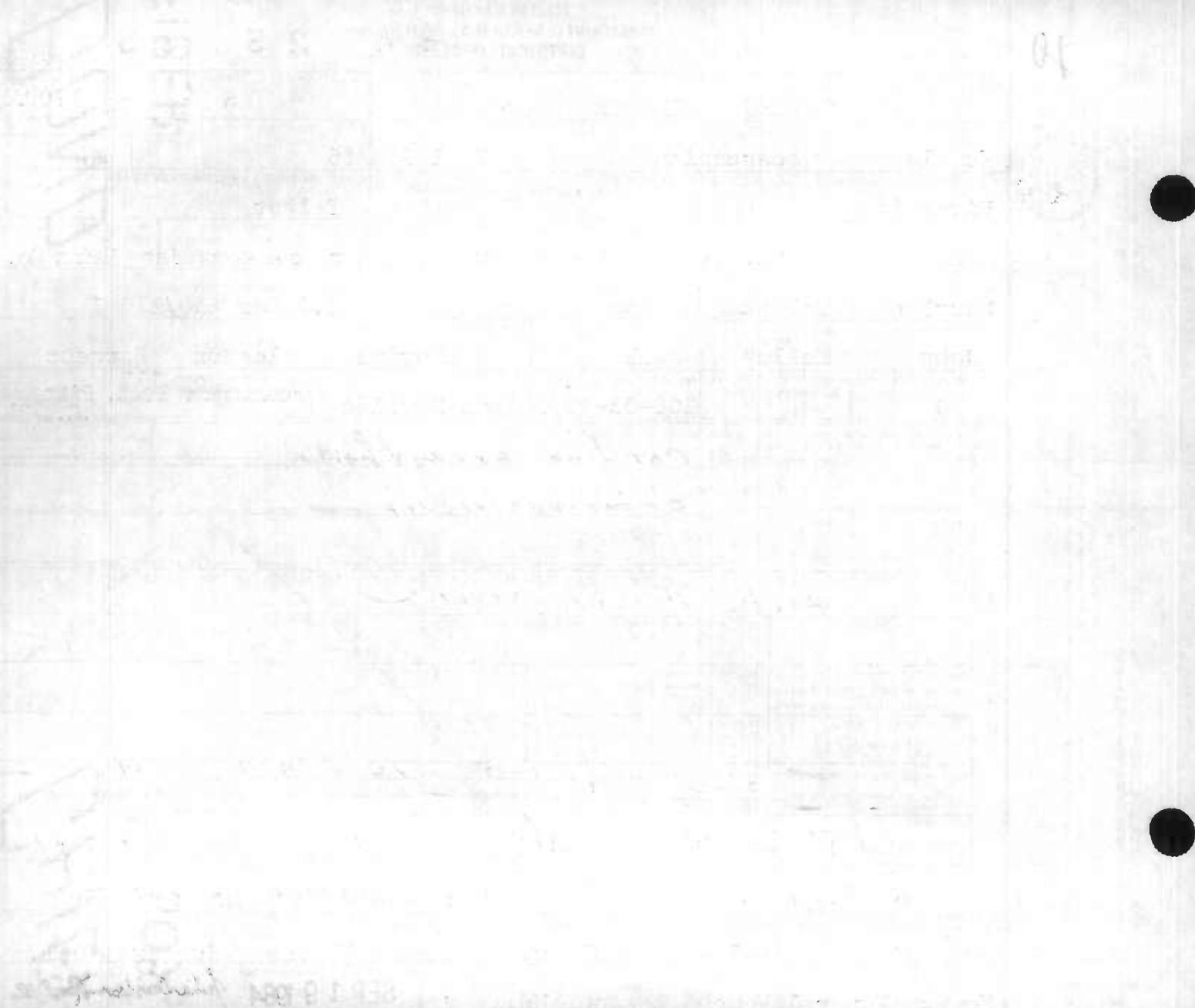
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25735 REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			9 16 84		1:00AM		
FRANCES ELEANOR GRONER																
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
female			caucasian			MONTH 4 DAY 7 YEAR 1898			86			MONTHS		DAYS		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Virginia			USA						Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Easton			Rt. 4, Box 450, Locust Grove, Easton home economist									Heinz Co.				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			Talbot			Easton						Rt. 4 Box 450/21601				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
John			Kelle			Peck			Katherine			Eleanor			Barnett	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS				
NO			208-03-6365			Jane Sheilds			Cardiac arrhythmia			Box 112 Fearington Post, Pittsburgh N.C. 27312				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis				DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21a PART 1 or PART 2)										
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21h. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-17 1984 to 9-17 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>John H. Sanchez</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9-17-84							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R. B. Sanchez			22f. ADDRESS 722 commerce Dr. Easton													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-18-84			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes			COUNTY		STATE		
24 FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR SEP 19 1984			25b. REGISTRAR'S SIGNATURE <i>Julia L. Parker</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21 is marked as Item 18 showed any injury, or other traumatic event, the name of physician who treated the patient should be listed in Item 21.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25736		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Helen			Hollingsworth Hardee			9 14 84			7 45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		Caucasian		Feb. 16, 1900			84 YRS.					
7. BIRTHPLACE COUNTRY		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U. S. A.		Talbot								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Memorial Hospital		Seamstress			Sewing					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Caroline		Denton						7 North Fourth St. 21629		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
George		Margaret Rebecca Moore										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		212030832		Mr. Paul R. Hardee, Denton, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma inoperable to line of cleavage</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Paul R. Hardee</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9-14-84</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence D. Bohan</i>			22f. ADDRESS <i>Dutchmans Lane, Easton, Md. 21601</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/20/84			23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery			23d. LOCATION CITY OR TOWN Denton COUNTY Caroline STATE Md.			
24. FUNERAL DIRECTOR NAME <i>Moore Funeral Home</i>			25a. ADDRESS <i>Denton</i>			25b. DATE REC'D. BY REGISTRAR SEP 20 1984			25c. REGISTRAR'S SIGNATURE <i>Julie L. Darden-Randall</i>			

Topic

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene or to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25737	
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Woodrow Wilson						Harrington			September 25 1984 34				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS	
male		caucasian		6 2 19			65						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			TA/60+			
Maryland		USA								MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
EASTON		Memorial Hospital		Ser. Stat. Operator			Automotive						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Talbot		Easton						324 N. Washington St. 21601			
14. FATHER'S NAME		FIRST MIDDLE		LAST			15. MOTHER'S MAIDEN NAME						
Harry				Harrington			Lucy			Chance			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
YES		W W II		213-24-0203			Almira Harrington			see 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant lymphoma</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 yrs	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE
22a. I certify that (I) (this hospital) examined the deceased from <i>9/25/84</i> , 19, to 19, that (I) (we) last saw the deceased alive on <i>19</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE						22c. DATE SIGNED <i>9-25-84</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Easton, Md. 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-27-84		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill			23d. LOCATION CITY OR TOWN Easton		23e. COUNTY Talbot		STATE Md.		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 27 1984						25b. REGISTRAR'S SIGNATURE <i>La Davidson-Pendell</i>					
ADDRESS Easton, Md. 21601													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with "24 hours after death" with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner, if available, should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 4												25738 REC. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2. FIRST MIDDLE LAST				3a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 12 50 P.M.	
FLORENCE Florence				E. HASCHERT Haschert				9 29 84					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7d. 9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County							
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING WEEK) Cashier		13. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric							
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		15. CITY, OR TOWN Carroll		16. 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 439 HOOK Road 21157							
14. FATHER'S NAME FIRST George		MIDDLE A.		15. MOTHER'S MAIDEN NAME Dora		16. 17. INFORMANT C. Walter Haschert same as 13 e.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-05-4064 233-34-4325		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>heart failure</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiomyopathy</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic cardiovascular disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Arteriosclerosis</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 12 1983</i> to <i>Sept 29 1984</i> , that (I) (was) last saw the deceased alive on <i>Sept 17 1984</i> , and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death.													
22b. SIGNATURE <i>R. Sanchez</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		22e. MEDICAL DIRECTOR <input type="checkbox"/>		22f. STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED 9-29-84			
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. Sanchez</i>		22b. ADDRESS 322 Commerce Easton MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 10-1-1984		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood		23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		25a. ADDRESS 1050 York Road Towson, Maryland		25b. DATE REC'D. BY REGISTRAR OCT 2 1984		25c. REGISTRAR'S SIGNATURE Gwen Davidson-Kendall							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25739	REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
Charles Lloyd Haslup Jr.									Haslup Jr.			September 8 1984						11:26 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
male			caucasian			MONTH 12 DAY 5 YEAR 22			61			YRS			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			USA									Talbot								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
EASTON			Memorial Hospital			sales agent			Exxon Corp.											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE								
Maryland			Talbot			Easton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 3 Box 318/21601								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Charles			L.			Haslup Sr.			Katherine						Grauling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
YES			W W II			218-14-8259			Katherine Y. Haslup			Rt. 3 Box 318			Easton, Md. 21601					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Idiopathic cardiomyopathy</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			Uncertain					
DUE TO, OR AS A CONSEQUENCE OF (b) _____																				
DUE TO, OR AS A CONSEQUENCE OF (c) _____																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>None</u>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
19b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-24</u> , 19 <u>84</u> , to <u>9-8</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>9-8</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.																				
22b. SIGNATURE <u>Robert W. Trever, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9-10-84</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert W. Trever, M.D.</u>			22e. ADDRESS <u>RD 3 Box 297 Easton Md. 21601</u>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>9-11-84</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Oxford Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Oxford</u>			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME <u>Newnam Funeral Home, P.A.</u>			ADDRESS <u>Easton, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 11 1984</u>			25b. REGISTRAR'S SIGNATURE <u>Robert Trever</u>											

A

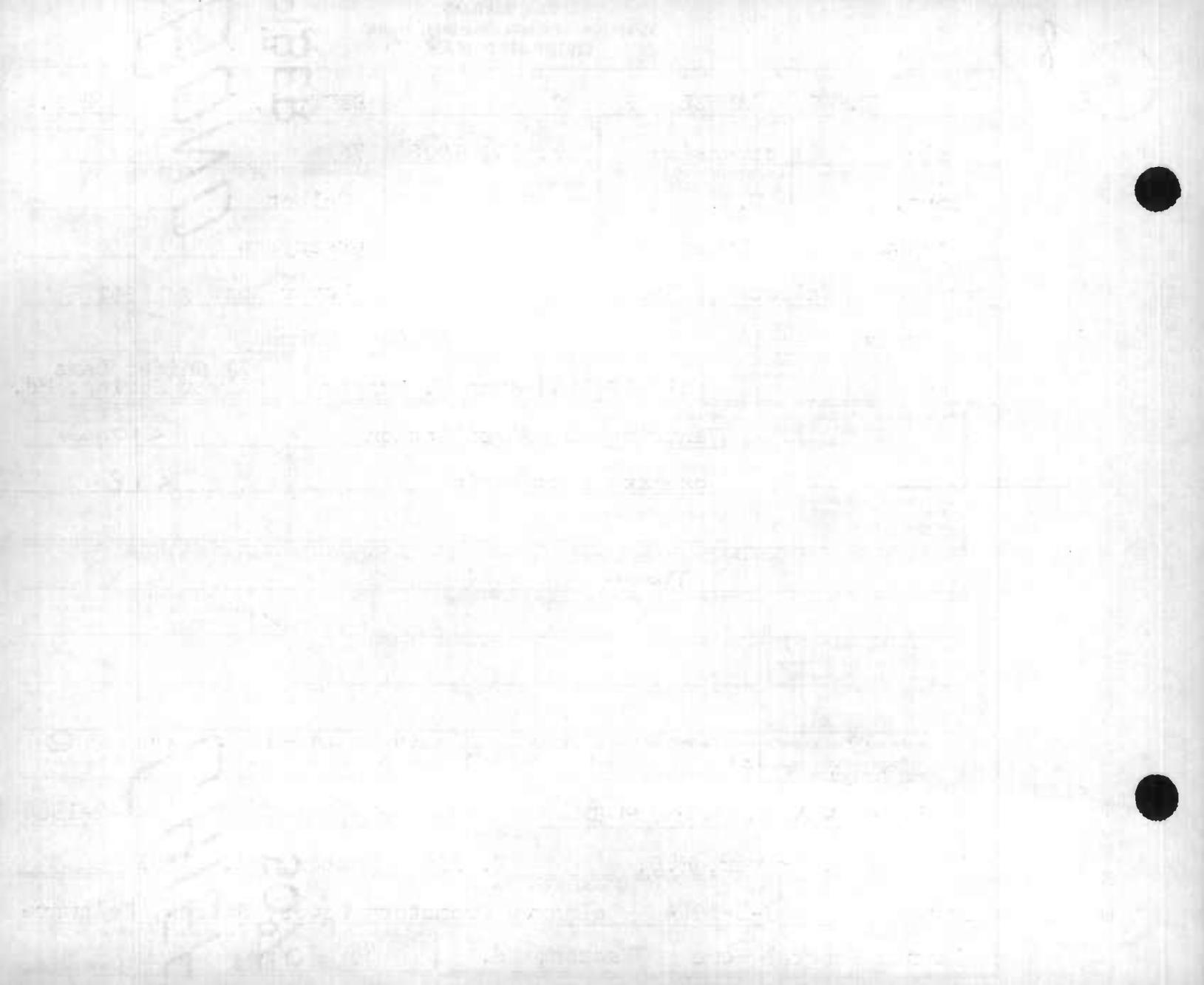


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be filled in before the certificate is signed.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25740											
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY			YEAR		2b. HOUR									
1. DECEASED NAME (TYPE OF PRINT)			FIRST MIDDLE LAST			2b. DATE OF DEATH			MONTH			DAY			YEAR		2b. HOUR						
ERNEST SAMUEL HEMMING						SEPT. 1, 1984									1984		2 A.M.						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
male			caucasian			Feb. 15, 1908			76			YRS.			MONTHS		DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Penns.			U.S.						Talbot			Easton			Dover Road			Nurseryman			MD.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE											
Maryland			Talbot			Easton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Dover Road / 21601											
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME																	
Ernest Hemming						Annie Bushman																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
no			212-10-7948			Anna H. Draper			821 Snider Lane Silver Spring, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 10 min</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) _____																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												None											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (1) (this hospital) attended the deceased from 9-1, 1984, to 9-1, 1984, that (1) (we) lost saw the deceased alive on 9-1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.												22c. DATE SIGNED 9-2-1984											
22b. SIGNATURE Robert W. Trever, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS RT. #50 Easton, Md. 21601														
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-2-1984			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware			25a. DATE REC'D. BY REGISTRAR SEP 6 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pender		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

Retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

DMMH - 16 50M 4/83  
(VRA 15, 4)FOR  
- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH2 5 7 4 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
MILDRED			ELLEN	HINER		9	19	84	4:15AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
female		caucasian		7	22	1900	84	YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Washington DC		USA					Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton		Meridian Nursing Center		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		99999			
S. Carolina				Columbia				1805 Devine St.					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Bernard		E.		McKeever		Mary		E.		Gates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		RT5 Box 386					
NO		215-30-6879		Lawrence E. Hiner, Jr.		Easton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>severe arteriosclerosis - cardiovascular disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>cerebrovascular disease</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. AUTOPSY*		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN)		CITY OR TOWN COUNTY STATE							
22a. I certify that (i) (this hospital) attended the deceased from <u>9-4</u> 19 <u>82</u> to <u>Sept</u> 19 <u>84</u> , that (i) (we) last saw the deceased alive on <u>9-1-84</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) (did not) view the body after death.												22b. DATE SIGNED <u>9-19-84</u>	
22c. SIGNATURE <u>R. Sanchez</u>		22d. DEGREE <u>MD</u>		22e. ATTENDING MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. Sanchez</u>		22g. ADDRESS <u>Commerce Dr. Easton MD</u>		23d. LOCATION CITY OR TOWN <u>Baltimore</u>		23e. COUNTY STATE <u>MD.</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 24 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John D. Wilson</u>			
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23c. DATE <u>9-21-84</u>		23d. NAME OF CEMETERY OR CREMATORIY <u>New Cathedral</u>		23e. ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>SEP 24 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John D. Wilson</u>			
24. FUNERAL DIRECTOR NAME <u>Newnam Funeral Home</u>		24b. ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>John D. Wilson</u>									

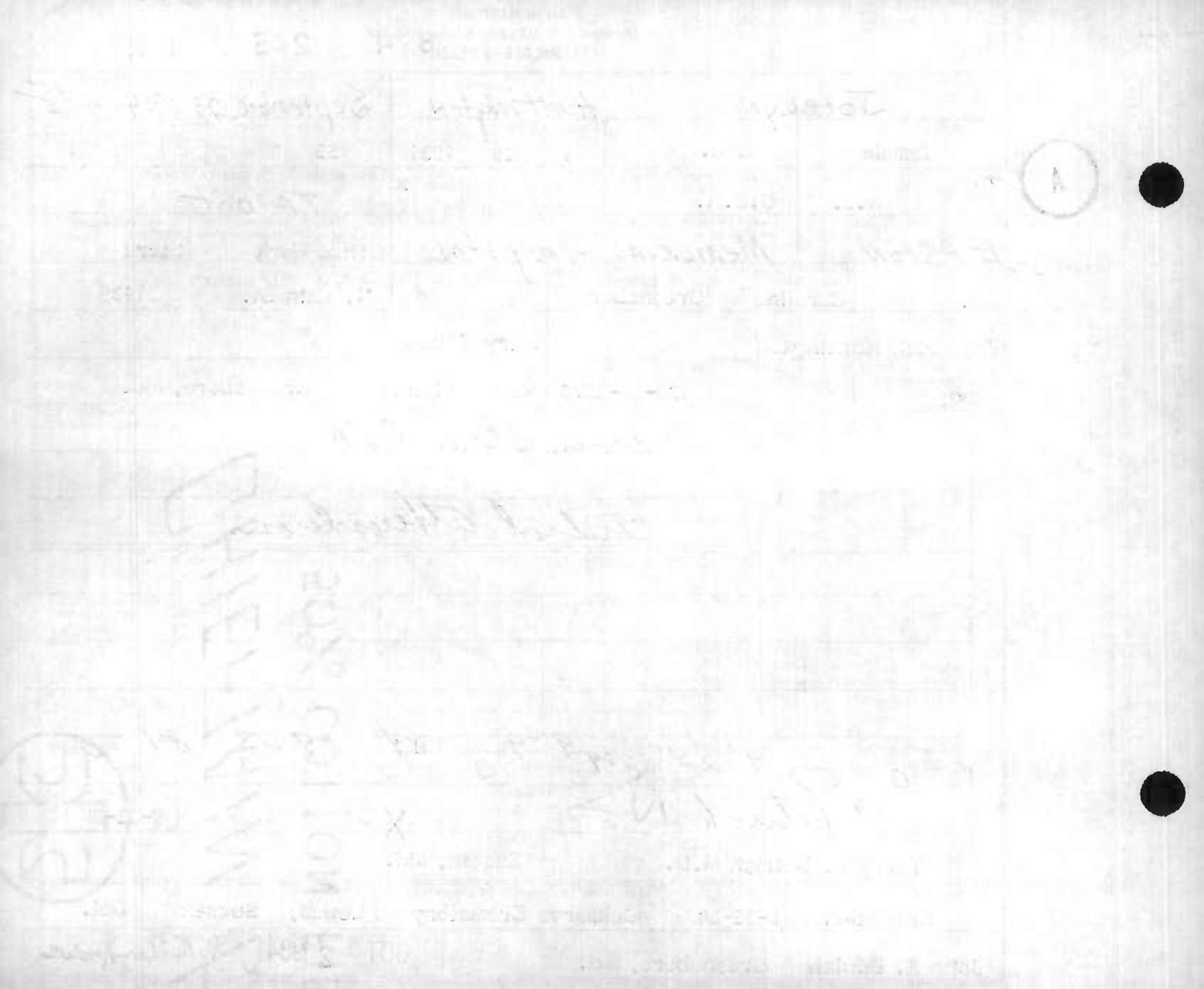


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25742								
1. DECEASED NAME (TYPE OR PRINT)										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)										26. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
1. SEX										1	26	1931	September 23 1984	4:35				
1. SEX										2. RACE	3. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
female										Cau.	MONTH	DAY	YEAR	MONTHS	DAYS	HOURS	MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?	8. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	YRS.	MONTHS	DAYS	HOURS	MIN.
N.J.										U.S.A.	MONTH		YEAR	53				
10. CITY OR TOWN OF DEATH										9. BALTIMORE CITY OR COUNTY OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY				
EASTON										Talbot				Store				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								
Memorial Hospital										Office Work								
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE								
13. STATE		13. COUNTY		13. CITY OR TOWN		N. Main St. 21639												
Md.		Caroline		Greensboro														
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME								
Frederick Huntington										Mary Cohen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)										16b. SOCIAL SECURITY NO.								
NO										135-26-2975								
17. INFORMANT										ADDRESS								
Nancy Nitchie										Greensboro, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) Brain Stem CVA																		
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Atherosclerosis																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED <small>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/></small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET		CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from <u>9-22</u> 19 <u>84</u> to <u>9-23</u> 19 <u>84</u> , that (2) (we) last saw the deceased alive on <u>9-22</u> 19 <u>84</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.																		
22b. SIGNATURE Terry P. Detrich M.D.										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. DATE SIGNED 9-23-84								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation										23b. DATE 9-23-84								
23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory										23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex Del.								
24. FUNERAL DIRECTOR NAME John E. Boulais ADDRESS Greensboro, Md.										25a. DATE REC'D. BY REGISTRAR OCT 2 1984								
										25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25743	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			26. HOUR				
Maynard W. Johnson						9 - 13 - 84			4:40 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Cau		June 8, 1912			72			YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Nebraska		USA					Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton		Memorial Hospital		Reg. V.P.			Agr. Manu.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS / ZIP CODE	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN St. Michaels			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Deep Water Point Rd 21663			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Charles Earl Johnson			Alverna May Kryder										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 074-01-4579			17. INFORMANT Lonnie B. Johnson, St. Michaels, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to liver</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Rt Colon</u> 8 mos.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/13/84</u> to <u>9/13/84</u> , that (I) (we) last saw the deceased alive on <u>9/13/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Wm H Wood			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 9/13/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood			22e. ADDRESS EASTON, Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 17, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Llano Cemetery			23d. LOCATION CITY OR TOWN Amarillo, Texas			24. DATE REGD. BY REGISTRAR IN REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR NAME Harmon E. Leonard St. Michaels, Md			ADDRESS SEP 20 1984										

Category: **Political** Date: **Sept 17, 1944** File No: **200-4525**

Names of key persons

Japanese held by

000-00-4525 Name: **Japan** No: **-----**

Names of key persons

Japanese held by

000-00-4525 Name: **Japan** No: **-----**

Names of key persons

Japanese held by

000-00-4525 Name: **Japan** No: **-----**

Names of key persons

Japanese held by

000-00-4525 Name: **Japan** No: **-----**

Names of key persons

Japanese held by

000-00-4525 Name: **Japan** No: **-----**

Names of key persons

Japanese held by

000-00-4525 Name: **Japan** No: **-----**

Names of key persons

Japanese held by

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be filled in.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 4 25144																	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE																	
CERTIFICATE OF DEATH																	
REG. NO.																	
1 - STATE (TYPE OR PRINT)			FIRST ELSIE			MIDDLE KELLUM			2a. DATE OF DEATH 9-30-84			2b. HOUR 8 A M					
3. SEX Female			4. RACE BLK			5. DATE OF BIRTH MONTH DAY YEAR 9 3 35			6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT			MD.					
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION Domestic			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md			13b. COUNTY Talbot			13c. CITY OR TOWN Cordova			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rafters Bay 287					
14. FATHER'S NAME Pleasance			15. MOTHER'S MAIDEN NAME Pierce			16a. SOCIAL SECURITY NO. 161-32-7646			17. INFORMANT Sonet			ADDRESS Thomas					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			LIVER AND KIDNEY FAILURE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS					
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA CERVIX UTERI												18 MONTHS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a INTESTINAL OBSTRUCTION																	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED I			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (1) <input type="checkbox"/> attended the deceased from MARCH 14, 19 83, to SEPT 30, 19 84, that (1) <input type="checkbox"/> last saw the deceased alive on SEPT 29, 19 84, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.																	
22b. SIGNATURE John A. Hankinson MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-30-84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE 10/4/84			23c. NAME OF CEMETERY OR CREMATORIAL New Haven			23d. LOCATION CITY OR TOWN Cordova, TA.			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME George Dashell			ADDRESS Easton, Md			25a. DATE REC'D. BY REGISTRAR OCT 4 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall								

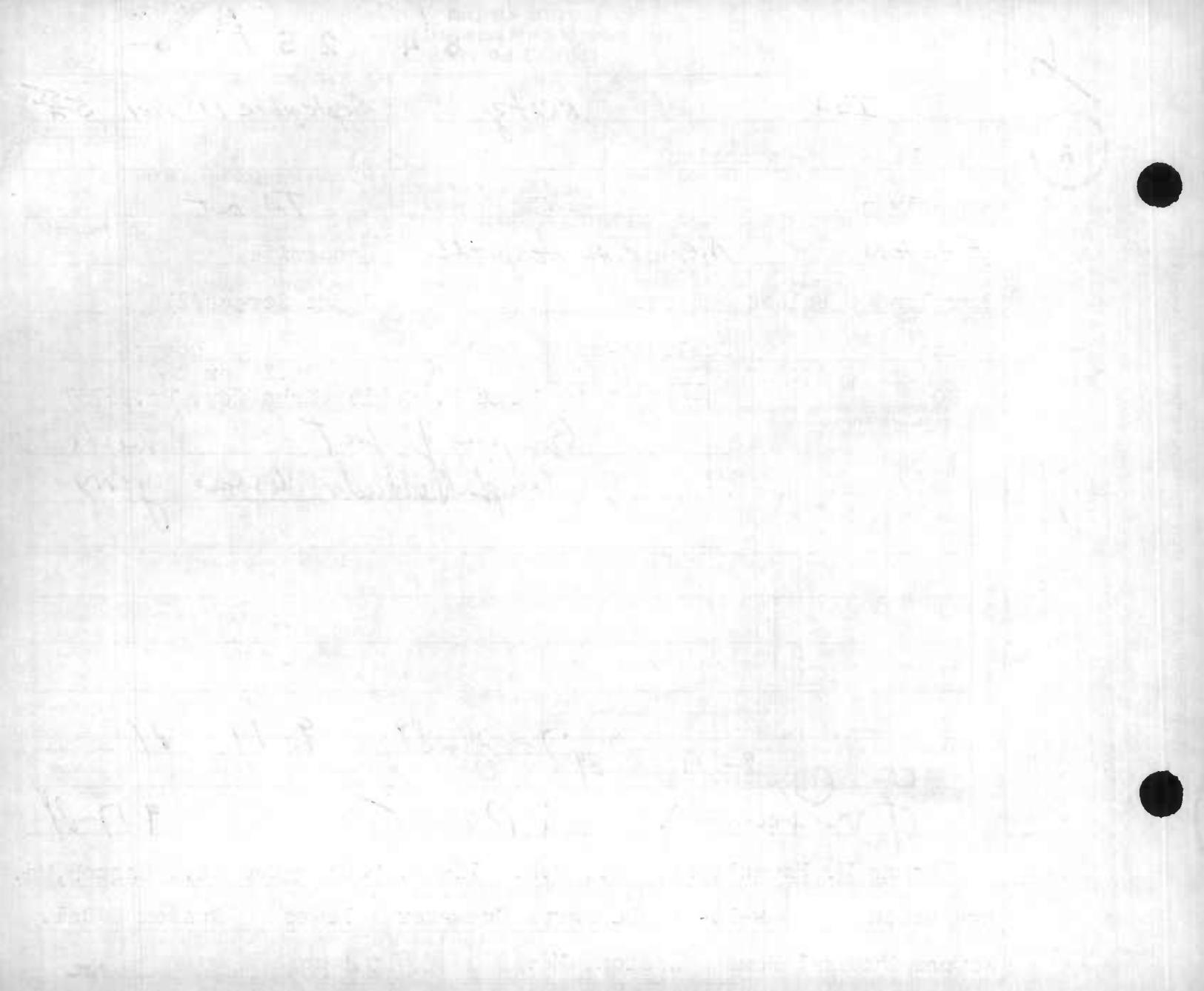


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25145			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
IDA					KRATZ	September 17 1984						5:55 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		Caucasian		MONTH	DAY	YEAR	81		MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
Pennsylvania		USA					TA/1bet			EASTON			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Memorial Hospital										Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Talbot		Easton						Judas Street/21601			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Otto				Schludecker	Sophie				Doerr				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS				
NO			177-09-8478			Janet L. Coble			Rt. 2 Box 289 Mahaffey, Pa. 25757				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										Gangrene of foot Peripheral vascular disease			
DUE TO, OR AS A CONSEQUENCE OF (b)										years			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 7-24-84 CITY OR TOWN 9-17-84 COUNTY 89 STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9-15-84, to 9-17-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Thomas W. Fauntleroy, Jr., M.D.			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-17-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 139 S. Washington St., Easton, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 9-19-84			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes COUNTY Sussex			STATE Del.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR SEP 24 1984			25b. REGISTRAR'S SIGNATURE John J. Fauntleroy				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transtom permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25146					
1. DECEASED NAME											REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Taylor			Ellsworth			Lambdin						9	24	84	8:00		
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
Male			Caucasian			3 15 24			60			MONTHS DAYS			HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			USA						Talbot County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton			Memorial Hospital			Auditor			St. of Md.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Talbot			Easton						410 Arbor Place/21601					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. ADDRESS								
William Lomax			Lambdin			Edna H. Harrison											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES			W W II			216-12-1351			Helen F. Lambdin see 13e.			Cancer 6 mo					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			DUE TO, OR AS A CONSEQUENCE OF (c)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET			21e. CITY OR TOWN			21f. COUNTY STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			21h. COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/24/84 to 9/24/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Stephen P. Carney, M.D.			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 8/25/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. ADDRESS			22g. ADDRESS			22h. ADDRESS			22i. ADDRESS		
Cremation			9-26-84			Delmarva Crematory			Lewes			Sussex			Del.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE		
Cremation			9-26-84			Delmarva Crematory			Lewes			Sussex			Del.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Newnam Funeral Home,			Easton, Md.			SEP 27 1984			Lie. Davidson-Randall								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25141			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Edith DODSON						Lee			Sept 22, 1984			12 24			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
FEMALE		CAUS.		JUNE 29, 1912			72								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MARYLAND		U.S.A.					TALBOT								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR PRINT, IF WORKING)			12b. KIND OF BUSINESS OR INDUSTRY								
EASTON		Memorial		ST. MICHAELS			HOUSEWIFE			HOME					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN ST. MICHAELS			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 410 WATER ST. 21663					
14. FATHER'S NAME FIRST MIDDLE		LAST			15. MOTHER'S MAIDEN NAME LAST										
ROBERT S. DODSON					ETHEL WATKINS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		217-54-6045			JANE LEE TYLER			Sub acute cerebral hemorrhage			one day				
								Hypertension			over 10 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE Lawrence D. Bohan M.D.		22c. DEGREE	
22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED 9-24-84									
22h. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence D. Bohan M.D.		22i. ADDRESS DUTHCMANS, LANE EASTON, Md. 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 25, 1984		23c. NAME OF CEMETERY OR CREMATORIUM OLIVET CEMETERY ST. MICHAELS, TALBOT			23d. LOCATION CITY OR TOWN TALBOT		23e. COUNTY MARYLAND		23f. STATE				
23g. FUNERAL DIRECTOR NAME Lawrence D. Bohan, M.D.															

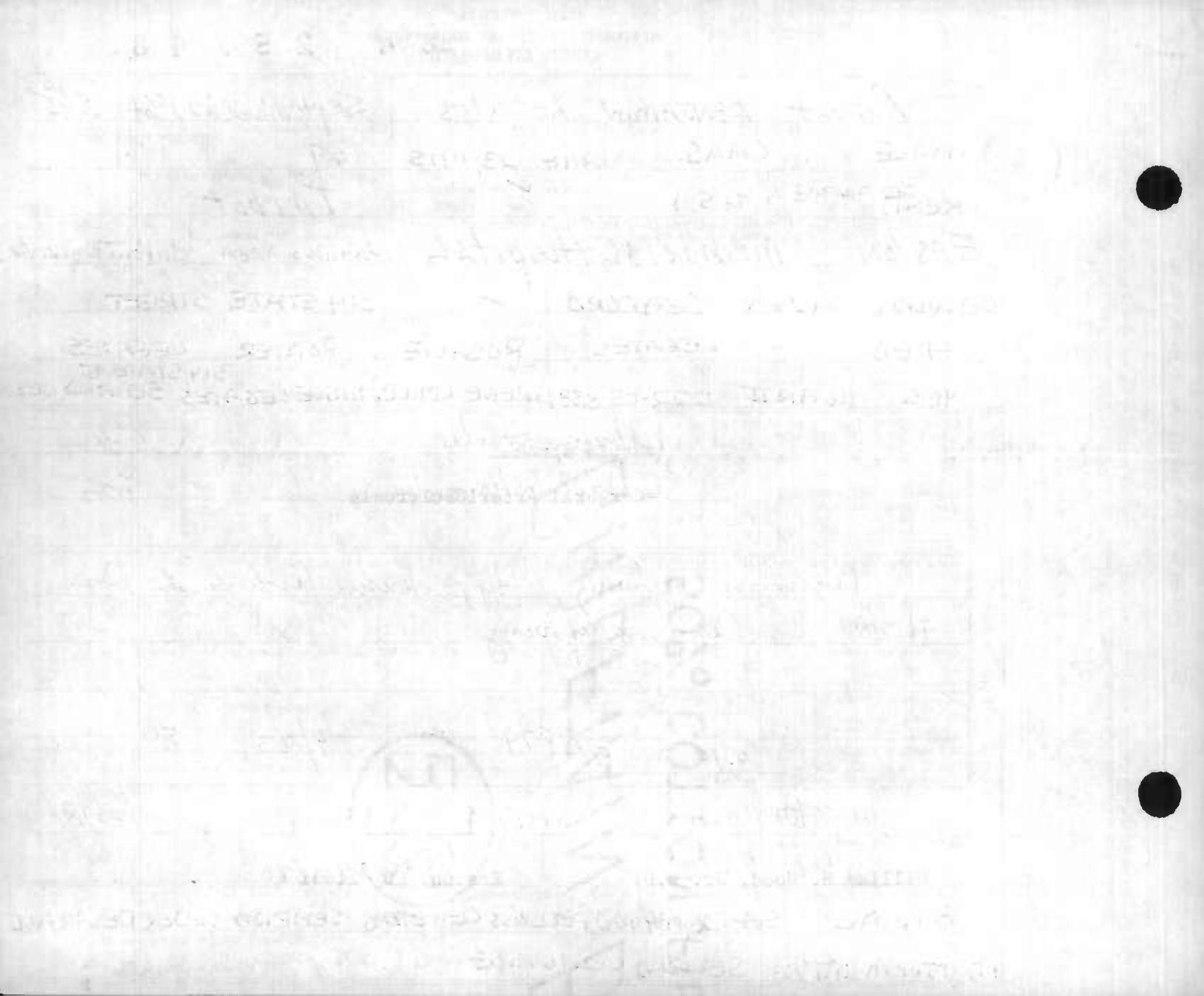
2020-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other traumatic event, the medical examiner may be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25748	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Robert BENJAMIN Legates						September 23 1984			5:10 AM				
SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE		CAUS.		AUG. 23 1915			69			MONTHS DAYS HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH						
DELAWARE (KENT)		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			TA/bot						
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
EASTON		Memorial Hospital		SPINNING & ARSEN			DURANT TAYLOR CO.			99999			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. STREET ADDRESS / ZIP CODE						
DELAWARE		SUSSEX		SEAFORD			314 STATE STREET						
14. FATHER'S NAME		MIDDLE		15. MOTHER'S MAIDEN NAME			MIDDLE			LAST			
FRED		— LEGATES		ROSALIE			POINTER			LEGATES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
YES		WANII 222-05-8539		IRENE COULBOURNE LEGATES SEAFORD, DEL			6 day						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Stroke</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Atherosclerosis</u>												1/2	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Circumcis. of penis</u> <u>Hyper tension</u> <u>Cardiovascular Disease</u>													
19a. DATE OF OPERATION 9/13/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Circumcis. of penis</u>		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21 OF PART 1)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/19/84 to 9/23/84, that (I) (we) last saw the deceased alive on 9/19/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Wm H. Wood		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/26/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Wood, MD		22e. ADDRESS EASTON, MD 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE SEPT 26 1984		23c. NAME OF CEMETERY OR CREMATORIAL PELLOWS CEMETERY			23d. LOCATION CITY OR TOWN SEAFORD SUSSEX DELAWARE						
24. FUNERAL DIRECTOR NAME Paynter M. Watson		ADDRESS SEAFORD SUSSEX DELAWARE		25a. DATE REC'D. BY REGISTRAR 01.10.84			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pender						



**Medical Examiner Notified**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached to use as the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being a violent injury, or other traumatic event, the medical examiner must be notified.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25149																	
1. DECEASED NAME (TYPE OR PRINT)				FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR													
H. Helen Deborah									Lewis			9	20	84	7 05														
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS																
F		W		Aug 13, 1892			92			YRS			MONTHS DAYS HOURS MIN.																
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Maryland		US.A.					Talbot			Easton			Memorial Hospital			Housewife													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
Maryland		Q.A.		Chester			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Rt. 1 Box 497-E 21619			Hugh Harris			Deborah Timms													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			19. DATE OF OPERATION			20. CONDITION FOR WHICH OPERATION WAS PERFORMED			20b. AUTOPSY			20c. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
No		215-38-2128		Estella M. Roe, Rt. 1 Box 285J, Chester			acute pulmonary edema			MD 21619			9/17/84			Amputation (L) hip			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCD</i> = coronary artery disease			DUE TO, OR AS A CONSEQUENCE OF (c) <i>severe acute + chronic - VRS</i> <i>liver failure heart failure</i>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Renal insufficiency - Recent bone marrow transplant -</i>			21. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19			22. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			23. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —			24. LOCATION STREET —			CITY OR TOWN —			COUNTY —			STATE —		
22a. I certify that (I) (this hospital) attended the deceased from the deceased alive on <i>9/20 1984</i> and that in my (our) opinion death occurred on the date and hour and I am the causes stated above. (I/we did (did not) view the body after death.)			25. SIGNATURE <i>Albert T. Dunkin Jr.</i>			26. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22b. ADDRESS Albert T. Dunkin Jr. Route 3 Box 127 EASTON MARYLAND 21601			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 09/23/84			23c. NAME OF CEMETERY OR CREMATORIAL Stevensville Cemetery			23d. LOCATION CITY OR TOWN —			COUNTY —			STATE —		
24. FUNERAL DIRECTOR NAME Helfenbein Funeral Home			25a. DATE REC'D. BY REGISTRAR SEP 28 1984			25b. REGISTRAR'S SIGNATURE <i>Albert T. Dunkin Jr.</i>																							

A

12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 7 5 Q  
REG. NO.

**1- FOR  
STATE  
REGISTRAR**

1. DECEASED NAME (TYPE OR PRINT)		1. FIRST DAVID	1. MIDDLE ROLPH	1. LAST LONGFELLOW	2. DATE KNOWN OF EST. DEATH MATED	2. MONTH 9	2. DAY 14	2. YEAR 84	2. HOUR 11:00 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.				
male	Cauc.	9 19 21	62 yrs.						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Talbot			
Maryland		USA							
13. CITY OR TOWN OF DEATH Easton		14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goldsborough Neck Rd., Easton				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor			
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 314 Linden Ave. Easton, Md.	
14. FATHER'S NAME FIRST Frank		MIDDLE Herbert		LAST Longfellow		15. MOTHER'S MAIDEN NAME FIRST Phoebe		16. KIND OF BUSINESS OR INDUSTRY Serv. Station	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W W II		16c. INFORMANT Elizabeth D. Longfellow		16d. ADDRESS see b.e.			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>gunshot wound left chest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).									
20. MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH		21b. TIME OF INJURY HOUR & MINUTE MONTH DAY YEAR 11:00 9 14 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20a) <i>left Unplotted</i>			
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (ADDRESS HOME, FACTORY, FARM, ETC.) <i>farm field</i>		21f. LOCATION CITY OR TOWN <i>Fulton</i>			
		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE (SPECIFY) <i>9-17-84</i>		22c. MEDICAL EXAMINER <i>Deputy</i>		22d. DATE SIGNED <i>9-17-84</i>	
		ACTUAL SIGNATURE <i>Ron Carroll</i>		N.D.					
		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23. BURIAL/CREMATION/REMOVAL		23b. DATE 9-17-84		23c. NAME OF CEMETERY OR CREMATORIUM Oxford Cemetery		23d. LOCATION CITY OR TOWN Oxford		23e. COUNTY Talbot	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 19 1984		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendell</i>	
BP									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "RENDING" IN BLOCK IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 1, WITH FORM FM 3, RETAIN PAGE 4, SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

OHMH-17  
(VR A15 ME (5))  
15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

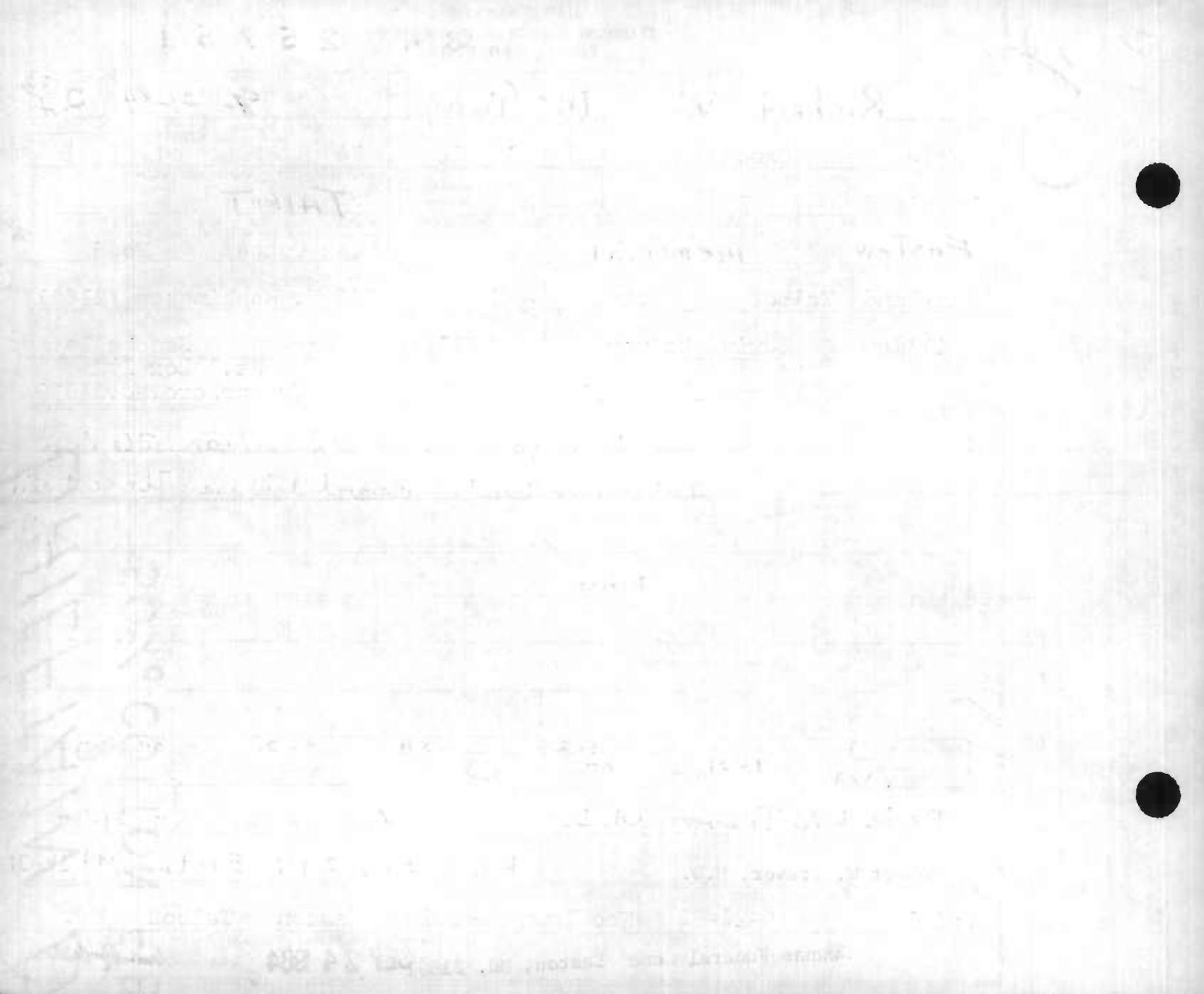
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH25751  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	3b			
Richard W.					McQuay	9-21-84				24	AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Male		Caucasian		7	8	10	74		MONTHS	YEARS	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA					Talbot			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
EASTon		Memorial		Meat Cutter			Food							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE						
Maryland		Talbot		Easton				326 N. Washington, /21601						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME									
		William	Edwin	McQuay	Lillian		Middle	LAST	Sheckells					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Yes		WWII-Army		212-10-7942		Anna K. Ebling		Rt. 1 Box 202			36 hrs.			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Acute myocardial infarction		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease		ADDRESS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						DUE TO, OR AS A CONSEQUENCE OF (c)					Uncertain			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
None														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (1) this hospital attended the deceased from 1-25, 1984, to 9-21, 1984, that (1) (we) lost saw the deceased alive on 9-21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.														
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		DATE SIGNED				
Robert W. Trever, M.D.				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		9-21-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
Robert W. Trever, M.D.		RD3 Box 297		Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE				
Burial		9-24-84		Woodlawn Memorial		Easton		Talbot		Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Newnam Funeral Home		Easton, Md. 21601		SEP 24 1984		Julia Davidson-Pendell								



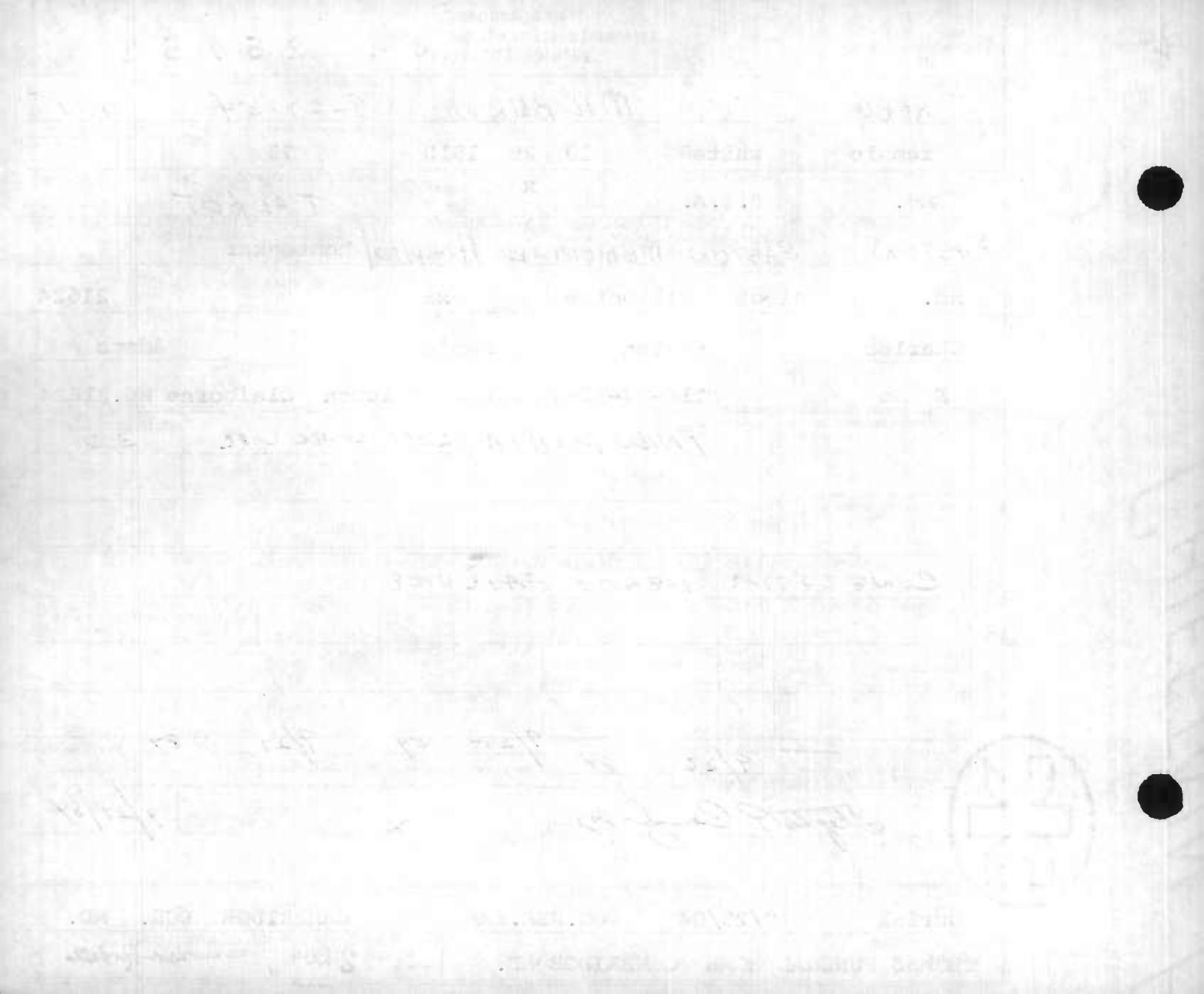
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25752	
1. DECEASED NAME FIRST MIDDLE LAST											2d. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
RUBY V MIL BURN											9-27-84	8:01 AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH 10 DAY 29 YEAR 1910			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.						
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Claiborne			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21624				
14. FATHER'S NAME FIRST Charles		MIDDLE Wrotten		15. MOTHER'S MAIDEN NAME FIRST Manie			MIDDLE			LAST Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N No		16b. SOCIAL SECURITY NO. 214-07-9367		17. INFORMANT Lester Milburn			ADDRESS Claiborne Md. 21624						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PNEUMONIA, LEFT LOWER Lobe												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 D	
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). CONGESTIVE HEART FAILURE													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (1) (the physician) attended the deceased from 9/25/84 to 9/27/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/27/84						
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/29/84		23c. NAME OF CEMETERY OR CREMATORIAL DOR. MEM. PARK			23d. LOCATION CITY OR TOWN CAMBRIDGE			COUNTY DOR. MD. STATE			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR 2/19/84			25b. REGISTRAR'S SIGNATURE Jicha Davidson-Randall						
DHMH - 16 50M 4/B3 (VRA 15. 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25753						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Patricia Parmenter	Patricia			Parmenter			Miscall			Sept	9	84		2A		
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS			
Female	Cau.			Month Day Year			63			MONTHS DAYS			HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
France	USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Easton	Memorial Hospital										(Ret.) Dept of Health					
13a. STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE								
Maryland	Talbot		St. Michaels		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt #1, Box 199 21663								
14. FATHER'S NAME	FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME												
Richard Parmenter				Isabella Burrall												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No	025-18-5031			Jack L. Miscall			Rt 31, Box 199			St. Michaels, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										RESPIRATORY ARREST						
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BRONCHIOGENIC LUNG CARCINOMA																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 9/18 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) saw the body after death.										22c. DATE SIGNED 9/9/84						
22b. SIGNATURE Wm S. BREMER MD										DEGREE MD	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm S. BREMER MD										22e. ADDRESS St. MICHAELS Md 21663						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE						
Cremation		Sept 11, 1984		Ft. Lincoln Cem.			Brentwood		P.G.	Maryland						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Dorothy E. Leonard		St. Michaels, Md.			SEP 13 1984		John Henderson-Randall									



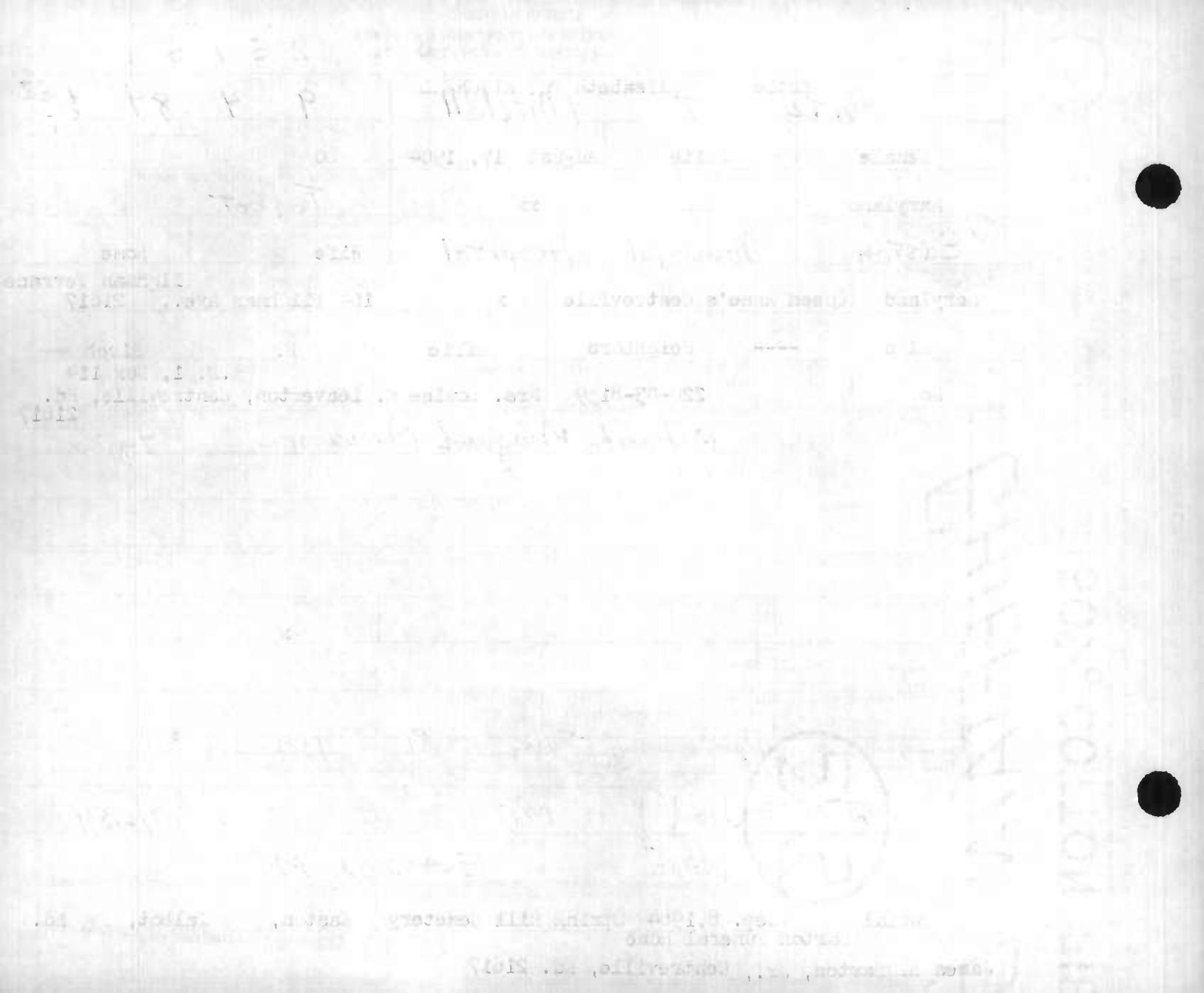
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filled with 70 helium after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25754					
1 - STATE REGISTRAR			2a DATE OF DEATH 9 4 84									2b HOUR 6:27 PM					
1 DECEASED NAME (TYPE OR PRINT) Artie Artie			MIDDLE Elizabeth T. MITCHELL			5. DATE OF BIRTH MONTH August DAY 17, 1904 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS			IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN. 0					
3. SEX Female			4. RACE White			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial Hospital									12a. USUAL OCCUPATION Wife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Queen Anne's			13c. CITY OR TOWN Centreville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Tilghman Terrace, 104 Tilghman Ave., 21617					
14. FATHER'S NAME FIRST Alga			MIDDLE -----			LAST Neighbors			15. MOTHER'S MAIDEN NAME Effie			ADDRESS R.D. 1, Box 114 Mrs. Louise M. Leaverton, Centreville, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-03-8159			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Malignant Melanoma DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH? 21617 7 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. 19 P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g. DEGREE MD			21h. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 9/6/84					
22a. I certify that (1) (this hospital) attended the deceased from 9/4/84 to 9/4/84, that (1) (we) last saw the deceased alive on 9/4/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			22b. SIGNATURE Wm H Wood			22c. ADDRESS EASTON MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sep. 8, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery			23d. LOCATION CITY OR TOWN Easton					
24 FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617			ADDRESS			25. DATE REC'D. FOR REGISTRATION SEP 1 1984			26. DATE REC'D. FOR ISSUANCE OF BURIAL PERMIT			27. DATE REC'D. FOR ISSUANCE OF CREMATORIAL PERMIT					
BP _____			DHHH - 16 50M 4/83 (VRA 15, 4)			28. DATE REC'D. FOR ISSUANCE OF CREMATORIAL PERMIT			29. DATE REC'D. FOR ISSUANCE OF BURIAL PERMIT			30. DATE REC'D. FOR ISSUANCE OF CREMATORIAL PERMIT					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

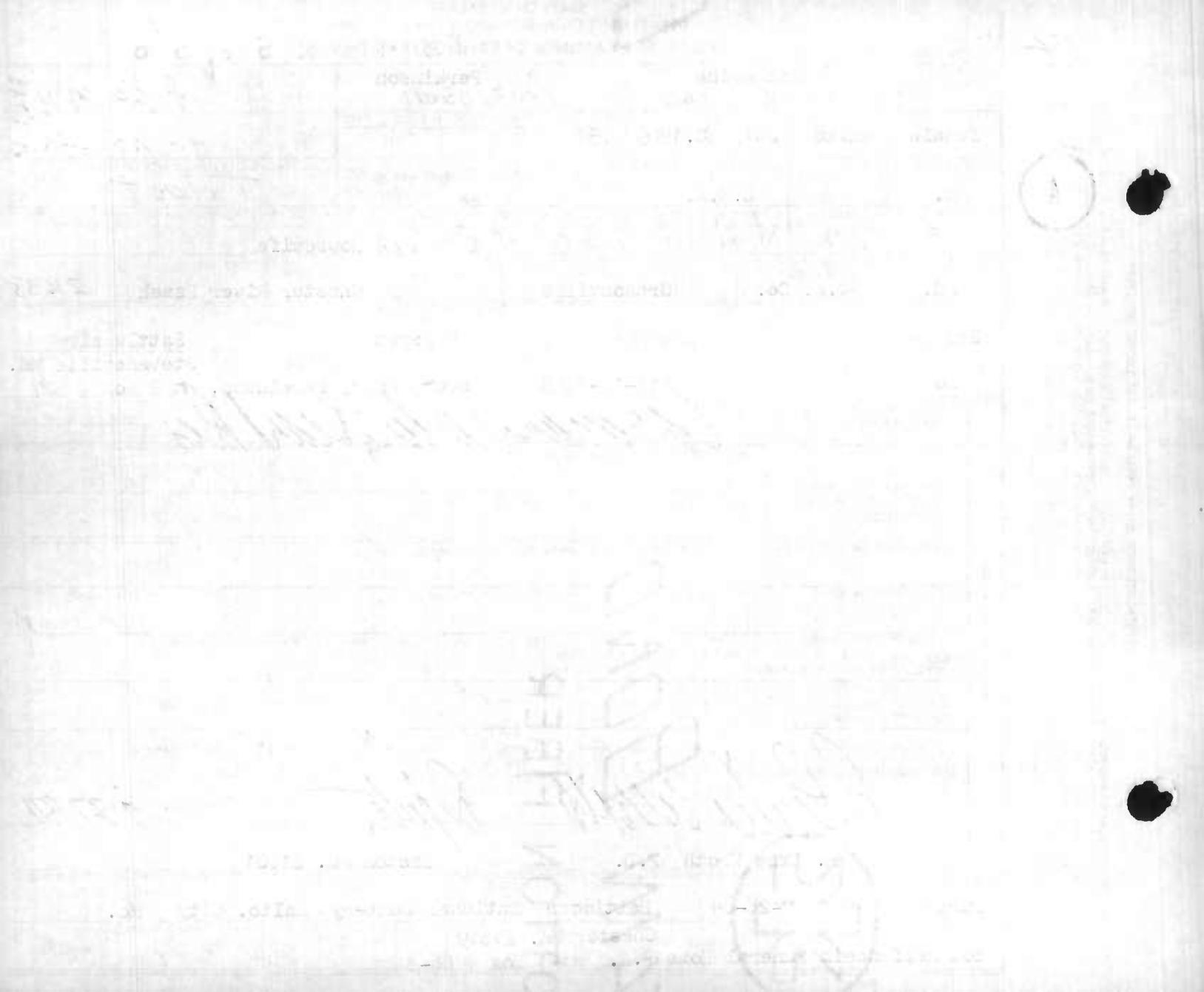
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25755		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
William J. Nollmeyer						9-5-84			7:42 AM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male		Caucasian		12 26 08			75							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA					Talbot							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton		Memorial Hospital at Easton					Wholesale dealer			Seafood				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Talbot		Oxford			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			318 Tilghman St./21654				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
James		Cronin Mary					216-09-0521			Anna M. Nollmeyer Box 147 Oxford, Md. 21654				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.														
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19, to <u>9/5</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.														
22b. SIGNATURE <u>Wm. H. Wood</u>		DEGREE MD			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									22f. DATE SIGNED 9/5/84			
Wm. H. Wood		Easton, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE	
Burial		9-7-84		Oxford Cemetery			Oxford			Talbot			Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Newnam Funeral Home, P.A.		Easton, Md.			SEP 10 1984			John Newnam						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE LEFT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5756		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	Catherine	MIDDLE	LAST	Perkinson	2a. DATE KNOWN OF ESTIMATED DEATH			MONTH	DAY	YEAR	2b. HOUR
Catherine Mary						Perkinson	9	25	84	10:44	AM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. MARRIED	10. NEVER MARRIED	11. WIDOWED	12. DIVORCED	13. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	14. TIME REC'D. BY REGISTRAR
female	white	Month July 30, 1909	75	YRS.	MONTHS DAYS HOURS MIN.					9 - 25 10 84	10:44	AM	10:44	10/25/84
15. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			16. MARRIED			17. BALTIMORE CITY OR COUNTY OF DEATH					
Md.			U.S.A.			<input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED			Talbot					
18. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton			Memorial Hospital at Easton			Housewife								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Md.			Q.A. Co.		Grasonville		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			Chester River Beach 21638				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
George					Krepner	Margaret					Sattlemair			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			21666 ADDRESS Stevensville Md.					
NO			213-10-3355			Robert Henry Perkinson, Pt#2 Box # 527								
18. CAUSE OF DEATH (Enter only one cause per line for line 1b, and 1c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 9-27-84		
ACTUAL SIGNATURE R. Lane Wroth M.D.			M.D. MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)			R. Lane Wroth M.D.									ADDRESS Easton Md. 21601		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial			9-28-84			Baltimore National Cemetery			Balto. City			Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			Chester Md. 21619			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Tom Helfenbein Funeral Home P.A.			Rt#1 Box # 66-B						OCT 3 1984			R. K. Wilson-Randall		
BP		DHMH - 17		(VR A15 ME (5))		20M 4/82								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25757	REG. NO.										
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR											
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.						
Louise			E. Pollard			White			4 19 18			66 YRS.			10 pm								
3. SEX			7. RACE			8. DATE OF BIRTH			9. BIRTHPLACE COUNTRY			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Female			White			MONTH 4 DAY 19 YEAR 18			Maryland			Eason			Memorial Hospital			Housewife			Home		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			Central Ave. 21660								
Maryland			Caroline			Ridgely												Sarah			VanSant		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Herman			Sarah			No			218-30-1454			Betty Baker			Pseudobulbar palsy			7					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral cerebral thromboses												Uncertain								
			DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												none											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9-30 19 84 to 9-30 19 84, that (I) (we) last saw the deceased alive on 9-30 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 10-1-84											
22b. SIGNATURE Robert W. Trever, M.D.			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Trever, M.D.			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-3-84			23c. NAME OF CEMETERY OR CEMETARY Ridgely Cemetery			23d. LOCATION CITY OR TOWN Ridgely			23e. COUNTY CA			MD								
24. FUNERAL DIRECTOR John E. Bouldin, Greensboro, NC			25. DATE RECEIVED BY REGISTRAR 8-1-84			26. REGISTRAR'S SIGNATURE John Davidson, Greensboro, NC																	

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

20100

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be completed and attached.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH25158  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR AM. OR PM.			
CARROLL ALVIN ROYER						9	10	84	6:00 AM.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		Caucasian		2 5 04			80 yrs						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA					Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton		417 S. Washington St.			Ret. Teacher			Education					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Talbot		Easton						417 S. Washington St /21601			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST			
John		T.		Royer			Anna			Weybright			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		216-09-1032		Mary P. Royer			see 13e.			8 YR 9 MO			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT LYMPHOMA													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-16, 1976, to 1-10, 1984, that (I) (we) last saw the deceased alive on 8-31, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
Stephen P. Carney, M.D.											9-10-84		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Cremation		9-10-84		Delmarva Crematory			Lewes			Sussex	Del.		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Newnam Funeral Home		Easton, Md.			SEP 11 1984			John Davidson - Pendleton					

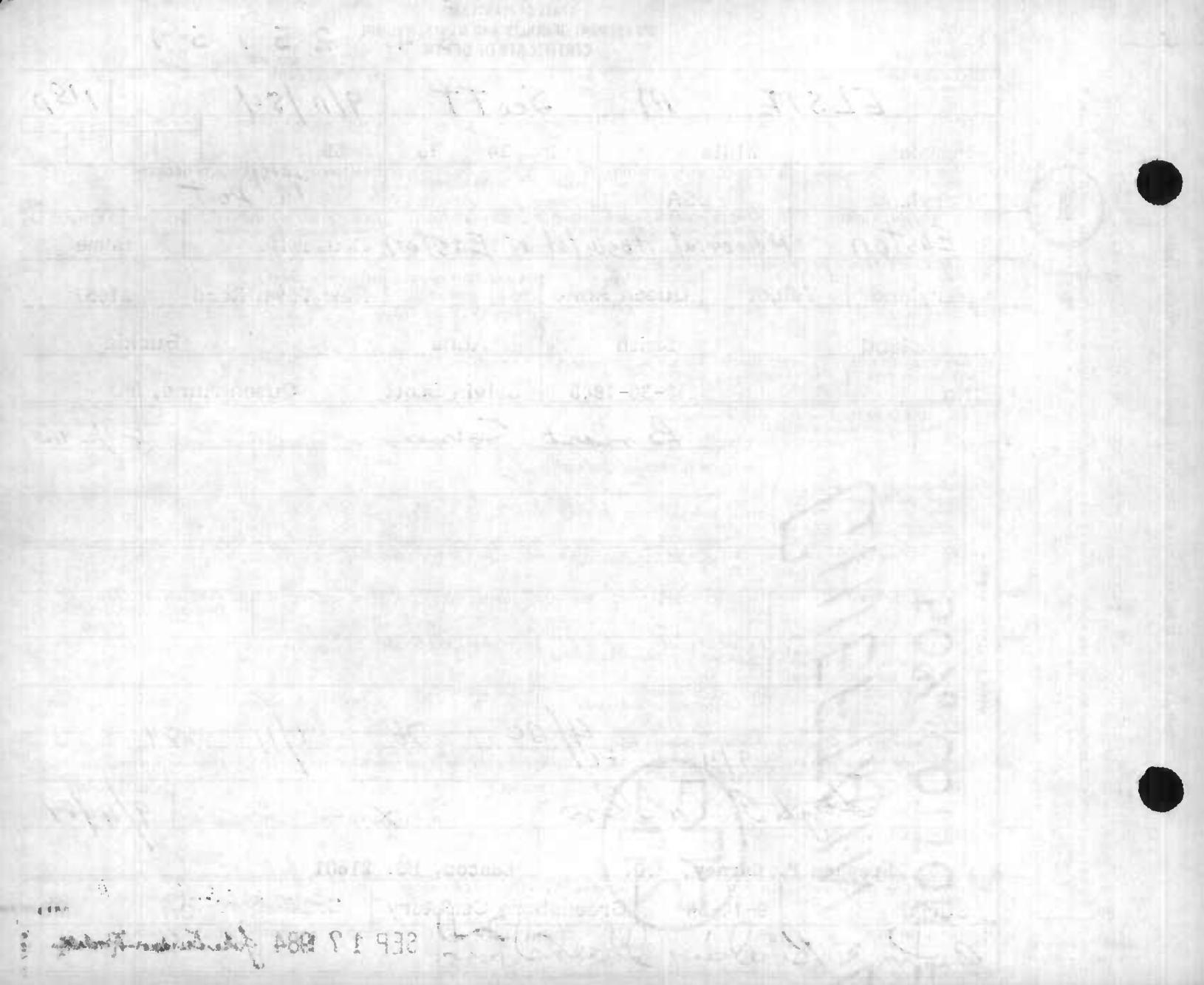


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-767-2200.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25759			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
ELsie				M.		Scott		9/11/84		2b. HOUR					
3. SEX				4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS MONTHS HOURS MIN.			
Female				White		7 24 15		69		YRS.		110 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Maryland				USA				Talbot							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Easton				Memorial at Easton								Housewife			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland				Talbot		Queen Anne		YES <input type="checkbox"/> NO <input type="checkbox"/>		New Town Road		Home			
14. FATHER'S NAME FIRST				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Roland						Smith		Anna				Buckle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No				218-30-1840		Calvin Scott		Queen Anne, MD				8/2/45			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
Breast Cancer															
DUE TO, OR AS A CONSEQUENCE OF (b)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)					21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/30, 1976, to 9/11, 1984, that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
saw the deceased alive on 9/11, 1984															
22b. SIGNATURE Stephen P. Carney, M.D.												22c. DATE SIGNED 9/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery				23d. LOCATION CITY OR TOWN Greensboro COUNTY CA STATE MD					
Burial				9-14-84											
24. FUNERAL DIRECTOR NAME John E. Bouldin				ADDRESS Greensboro		25a. DATE RECEIVED BY REGISTRAR SEP 17 1984				25b. REGISTRAR'S SIGNATURE John E. Bouldin					

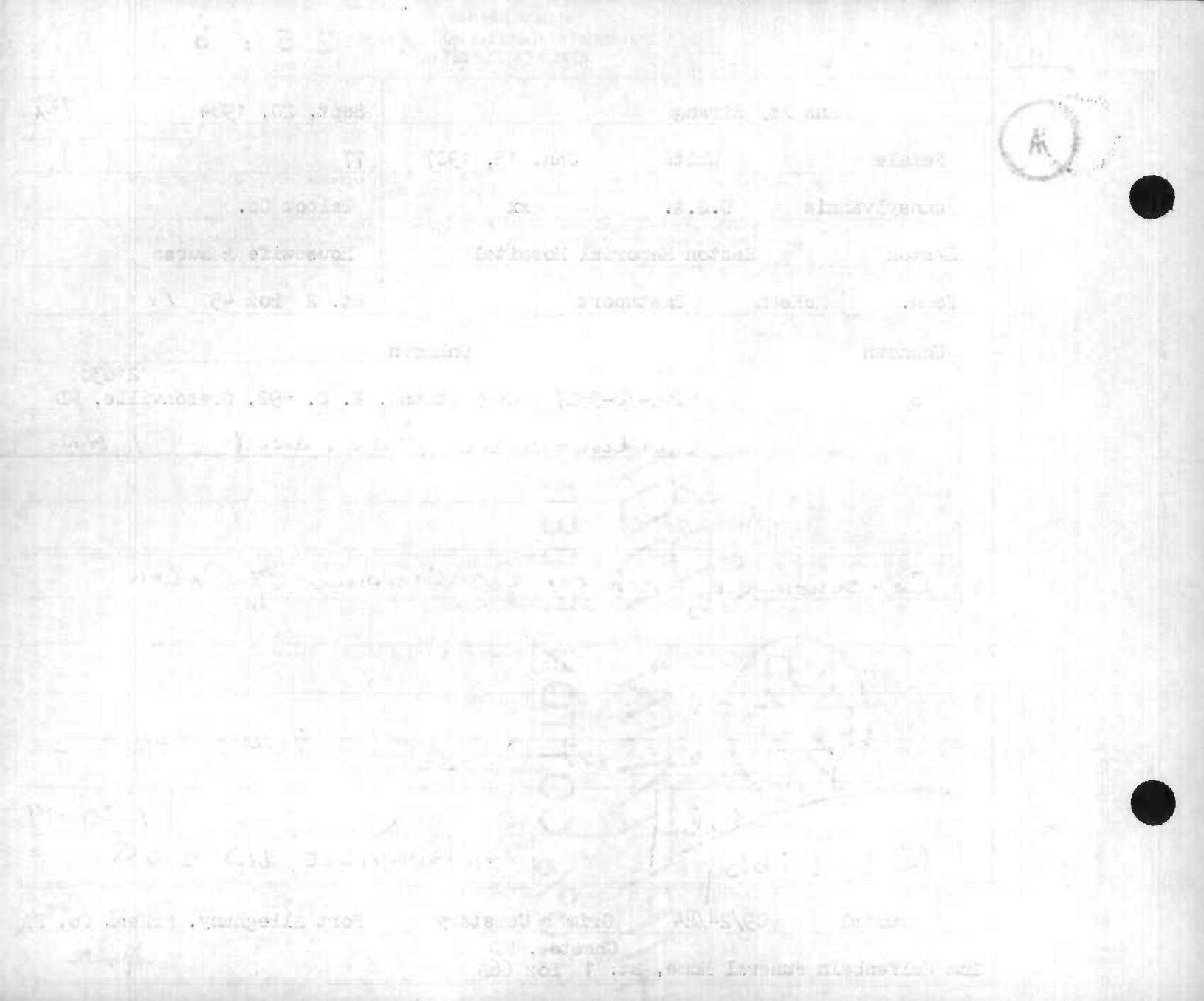


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25760	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Anna May Strang						Sept. 20, 1984			7:50 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		Jan. 13, 1907			77				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Pennsylvania		U.S.A.					Talbot Co.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Easton		Easton Memorial Hospital								Housewife & Nurse	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Penn.		McKean		Smethport			YES <input type="checkbox"/>		Rt. 2 Box 45		
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		
Unknown							Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS		21638		
No		203-30-9327		Gary Strang, P. O. 492, Grasonville, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardiovascular Accident										1 HR.	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c)											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of Breast & Carcinoma of Colon											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I, the physician) attended the deceased from 9-20 1984, to 9-20 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) did (did not) view the body after death.										22c. DATE SIGNED 9-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. E. Hibby										22e. ADDRESS GRASONVILLE, MD. 21638	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		09/24/84		Grimes Cemetery			Port Alleghany, McKean Co., PA				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Tom Helfenbein Funeral Home, Rt. 1 Box 66B		Chester, MD			SEP 27 1984			Wilson-Rendell			



*Medical Examiner Notified*

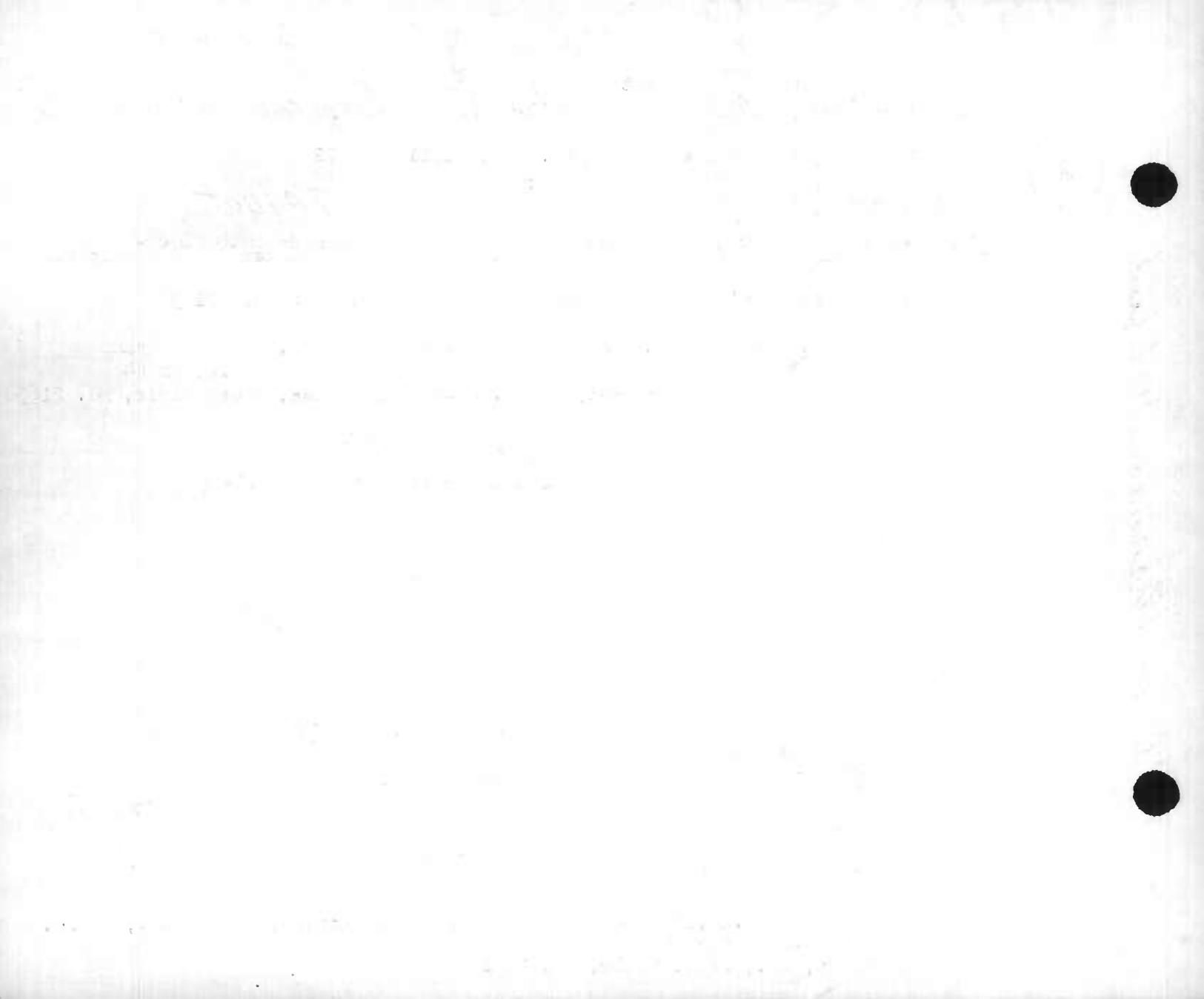
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 more be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked for Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25161			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Ralph M.		Ralph		Martin		Thomas		September 23 1984		11	35	1984	11 p.m.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 1 HRS.			
Male		White		Month Day Year Dec. 20, 1911		MONTH DAY YEAR 72		MONTHS DAYS		MONTHS DAYS HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA						Talbot					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY							
Easton		Memorial Hospital		Waterman-Boatbuilder-Carpenter		Seafood							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		QueenAnne's		Grasonville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 64, 21638					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Glen		Andrew		Thomas		Maude		B.		Mason			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		157-05-4179		Wife		P.O. Box 64							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		SEVERE BILIOUS EMPHYSEMA		PREMONIA					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (c)		Smoking							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) this hospital attended the deceased from <u>Sept 23 1984</u> to <u>Sept 23 1984</u> , that (2) we last saw the deceased <u>Sept 23 1984</u> , and that in [my] our opinion death occurred on the date and hour and from the causes stated above (1) we did (2) did not view the body after death.													
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				9/25/84							
Scott D. Freeman MD		403 Marvel Ct. Easton											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		Sep. 26, 1984		Woodlawn Memorial Park		Easton		Talbot		Md.			
24. FUNERAL DIRECTOR NAME		Barton Funeral Home ADDRESS		OCTO 01 1984		DATE RECEIVED BY REGISTRAR		25. REGISTRAR'S SIGNATURE					
James H. Barton, Jr., Centreville, Md. 21617								Jane W. Johnson-Pender					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death, and that it be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25762																			
										REG. NO.																			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. MONTH		2c. DAY		2d. YEAR		2e. HOUR														
			Dorothy Price Ulrich				9-21-84		1500		9-21-84		1500		1500														
3. SEX			4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS														
female			Caucasian		MONTH		DAY		YEAR		79				MONTHS		DAYS		HOURS		MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH														
Maryland			USA												Talbot														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																		
Easton			Memorial				Housewife																						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS / ZIP CODE									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE				501 Dutchman's Lane/21601												
Maryland			Talbot			Easton																							
14. FATHER'S NAME			FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME				FIRST		MIDDLE		LAST												
Harry							Price		May								Jarman												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
NO			215-44-6033				Mary D. Sisk				Car Pulmonary								yrs										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Interstitial Pulmonary Fibrosis</i>				DUE TO, OR AS A CONSEQUENCE OF (c) <i>Collagen Vascular Disease</i>								yrs														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE															
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 20</i> 1984, and (I) (we) last saw the deceased alive on <i>Sept 20</i> 1984, and (I) (we) did not view the body after death.										22b. DATE SIGNED 9/24/84																			
22c. SIGNATURE <i>Richard F. Manegold MD</i>										22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																			
22e. ADDRESS Richard F. Manegold, M.D. Easton, Md.										22f. ADDRESS Delmarva Crematory Lewes, Sussex, Del.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-25-84			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory				23d. LOCATION CITY OR TOWN Lewes				23e. COUNTY		23f. STATE													
Cremation														Sussex		Del.													
24. FUNERAL DIRECTOR NAME Newnam Funeral Home										25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRATION SIGNATURE SEP 25 1984 <i>Jane Johnson Pendleton</i>																			
ADDRESS Easton, Md.																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

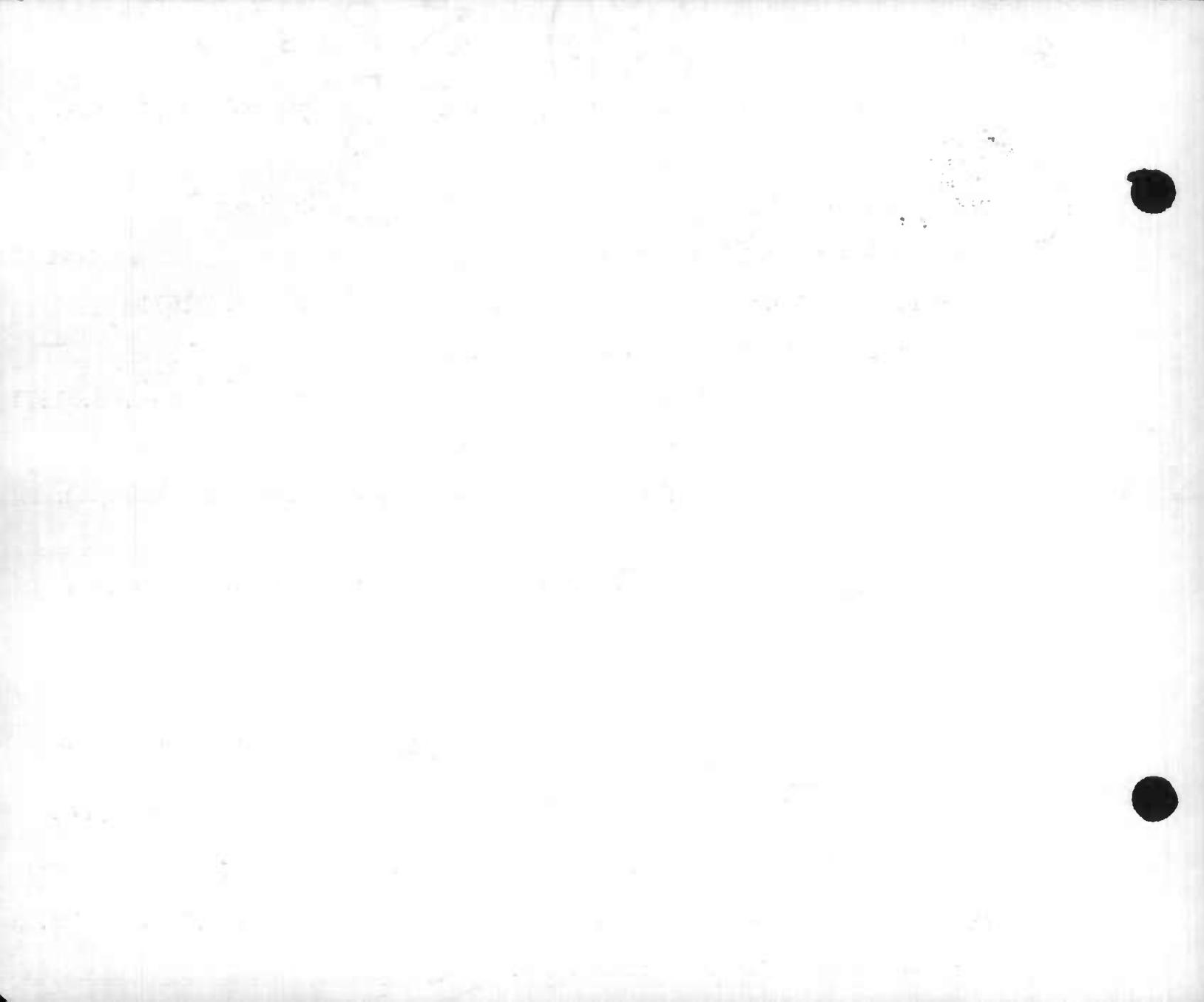
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25763		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			21b. HOUR					
George E. Wales						9-13-84			10:10 A.M.					
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR JAN. 16, 1922			6. AGE (IN YEARS LAST BIRTHDAY) 62			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER			12b. KIND OF BUSINESS OR INDUSTRY OIL COMP.							
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN ST. MICHAELS			13d. INSIDE CITY LIMITS? NO			13e. STREET ADDRESS / ZIP CODE MULBERRY ST. 21663				
14. FATHER'S NAME ROBERT D. WALES		LAST			15. MOTHER'S MAIDEN NAME JULIA R. WOODMENDER			MIDDLE			LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		16c. ADDRESS MULBERRY ST. IRENE B. WALES ST. MICHAELS, Md.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bruise Death</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Tract</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.														
22b. SIGNATURE <i>James Gieske, M.D.</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/13/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Gieske, M.D.		22e. ADDRESS Easton, Md. 21601												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 15, 1984			23c. NAME OF CEMETERY OR CREMATORIAL OLIVET CEM.			23d. LOCATION CITY OR TOWN ST. MICHAELS, TALBOT Md.						
24. FUNERAL DIRECTOR <i>Barry E. Leonard, M.D.</i>					25a. DATE REC'D. BY REGISTRAR SEP 20 1984			25b. REGISTRAR'S SIGNATURE <i>Barry E. Leonard, M.D.</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

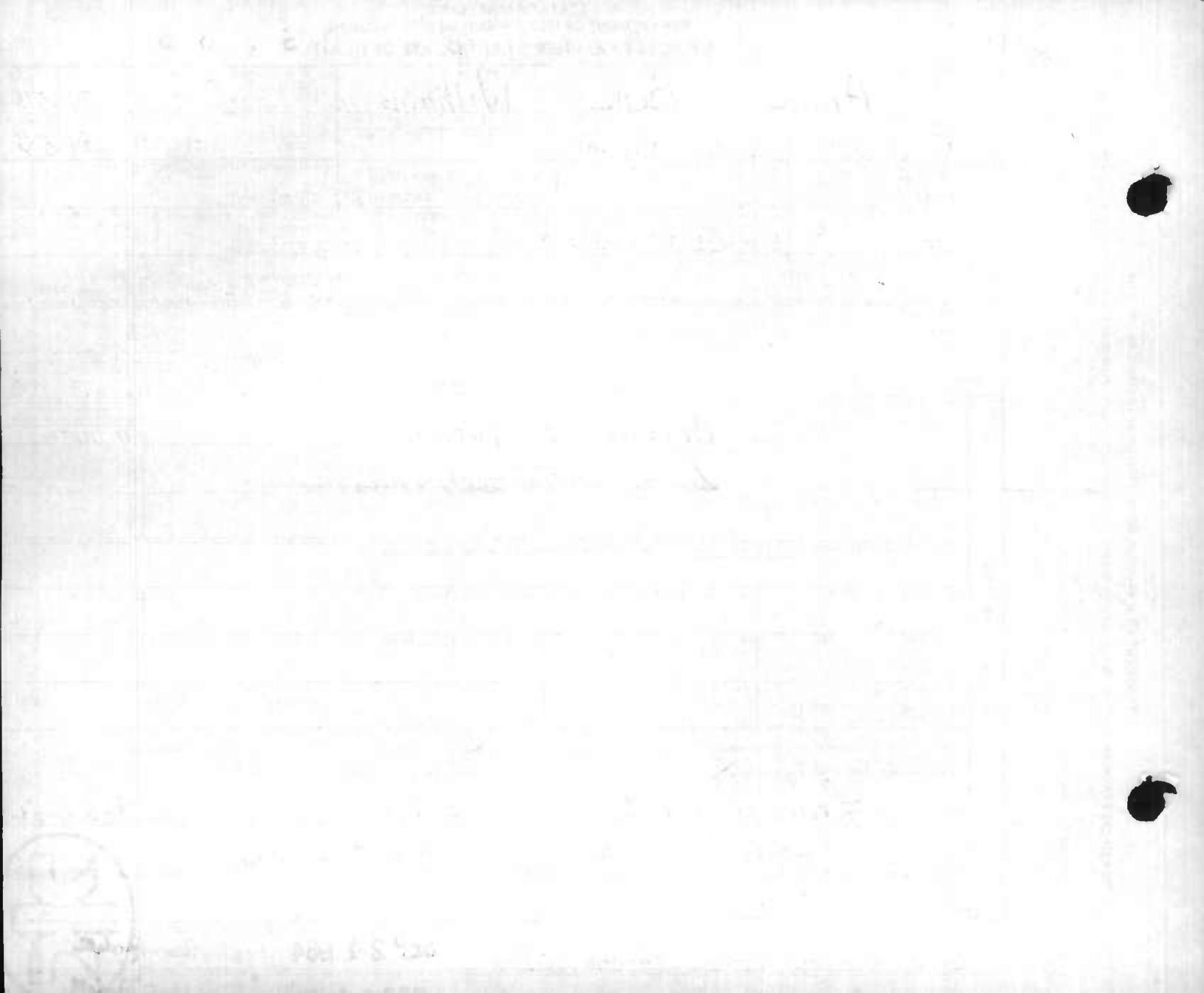
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25764					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			LAST			26. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR			
Warren A Wilbur						9-21-84						6:24PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Caucasian		MONTH	DAY	YEAR	74	YRS		MONTHS	DAYS	HOURS	MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		USA						Talbot MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton		Memorial			Manager			Singer Sewing Co							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS / ZIP CODE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			Taylor Ave. /21671								
Maryland		Talbot		Tilghman											
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME								
Robert		Eldridge		Wilbur			Nina		Vyse						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
YES		W W II			182-09-3425			Dorothy M. Wilbur		P.O. Box 195 Tilghman, Md. 21671					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Acute					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Heart Disease Years</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
<i>Carcinoma of Prostate with extensive metastases</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>9/21 1984</i> to <i>9/21 1984</i> , that (2) (we) last saw the deceased alive on <i>9/21 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Please see Dr. Greco</i>										22c. DATE SIGNED <i>9/21/84</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			22g. AGREE			22h. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
P. Greco Rhodes MD		503 Dutchman's Lane, Easton, Md. 21601			Not										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		9-25-84		Tilghman Methodist			Tilghman		Talbot		Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Newnam Funeral Home		Easton, Md.			SFP 25 1984			<i>John Newnam</i>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 7 6 5						
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- MATED									2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR			
Anna			Belle			Williams						9	19	1984	5:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				
F		W		2 26 23			61 yrs.			MONTHS		DAYS		HOURS		9 19 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		USA													Talbot			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital										Companian			MD. 21601			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			162E. Clearview Ave.					
Maryland		Talbot		Easton						Rt. 5 Box 368, Easton, Md.								
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			Mozer				
William		J.			McFarlane						Alpha							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										17. INFORMANT			ADDRESS			
NO		226-12-1984										Karen Donnelly			St. College, Pa. 16803			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe arteriosclerosis</i>																		
(c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
													<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. <i>for Dep</i>										MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										EASTON MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE						
Burial			9-22-84			Rose Lawn Cemetery			Marion			Va.						
24. FUNERAL DIRECTOR NAME		ADDRESS										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		Easton, Md.										SEP 24 1984			<i>Davidson-Bordell</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25766			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d DATE OF DEATH MONTH DAY YEAR			2b HOUR				
ARDELLA			WILLIAMS			9-28-84			10:25 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		B/K		10 05 00			83			YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Md		USA					Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Easton		THE MEMORIAL Hosp. at Easton Md								Domestic			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Md		Talbot		Easton		NO			Rt. 4 Box 523 21601				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
James		Mary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				Narcie Murray									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Cerebrovascular accident													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
(b) Cerebral arteriosclerosis													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from		22b. DATE REC'D. BY REGISTRAR		22c. DATE SIGNED									
saw the deceased alive on		1980, to 1984		9/28/84									
above, (I) (we) (did) (did not) view the body after death.													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Richard F. Manegold													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		10/5/84		Sanders town		Talbot T/A Md							
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Newell H. DesCheneaux		Talbot		OCT 4 1984		Julia Davidson-Randall							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be requested to examine the body.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25761		
										REG. NO.		
1 - STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	12 HOURS			
NELLIE			V.	WILLIAMS		9	27	84	12 PM			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
Female			White		MONTH	DAY	YEAR	77	IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Bridgewater DE			U.S.A.					TALBOT MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
EASTON			MEMORIAL HOSPITAL							Housewife		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Maryland			Caroline		Preston			13e. STREET ADDRESS / ZIP CODE				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			21655			
William Hastings						Nora Gilbert			21655			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
no			215-16-3279		Nancy L. Schiff, Rt 1, Box 247A, Preston, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Acute myocardial infarction										sudden		
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Disseminated, hyperacute coronary disease												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/29/84, 19, to 01/03/84, 19, that (I) <input type="checkbox"/> last saw the deceased alive on 01/03/84, 19, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not <input type="checkbox"/> did not view the body after death.										22c. DATE SIGNED		
22b. SIGNATURE Philip P. Felipe, M.D.										22c. DATE SIGNED 10/21/84		
22d. PHYSICIAN'S NAME (TYPE OF PRINT)			22e. ADDRESS									
Philip P. Felipe, M.D.			Denton, MD 21629									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial			Sept 30, 84		Bloomery Cemetery			Rt. Federalsburg		Caroline	MD	
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
FRAMPTON-HAWKINS			Box 43		FEDERALSBURG OCT 10 1984			Gloria Wilson-Randall				

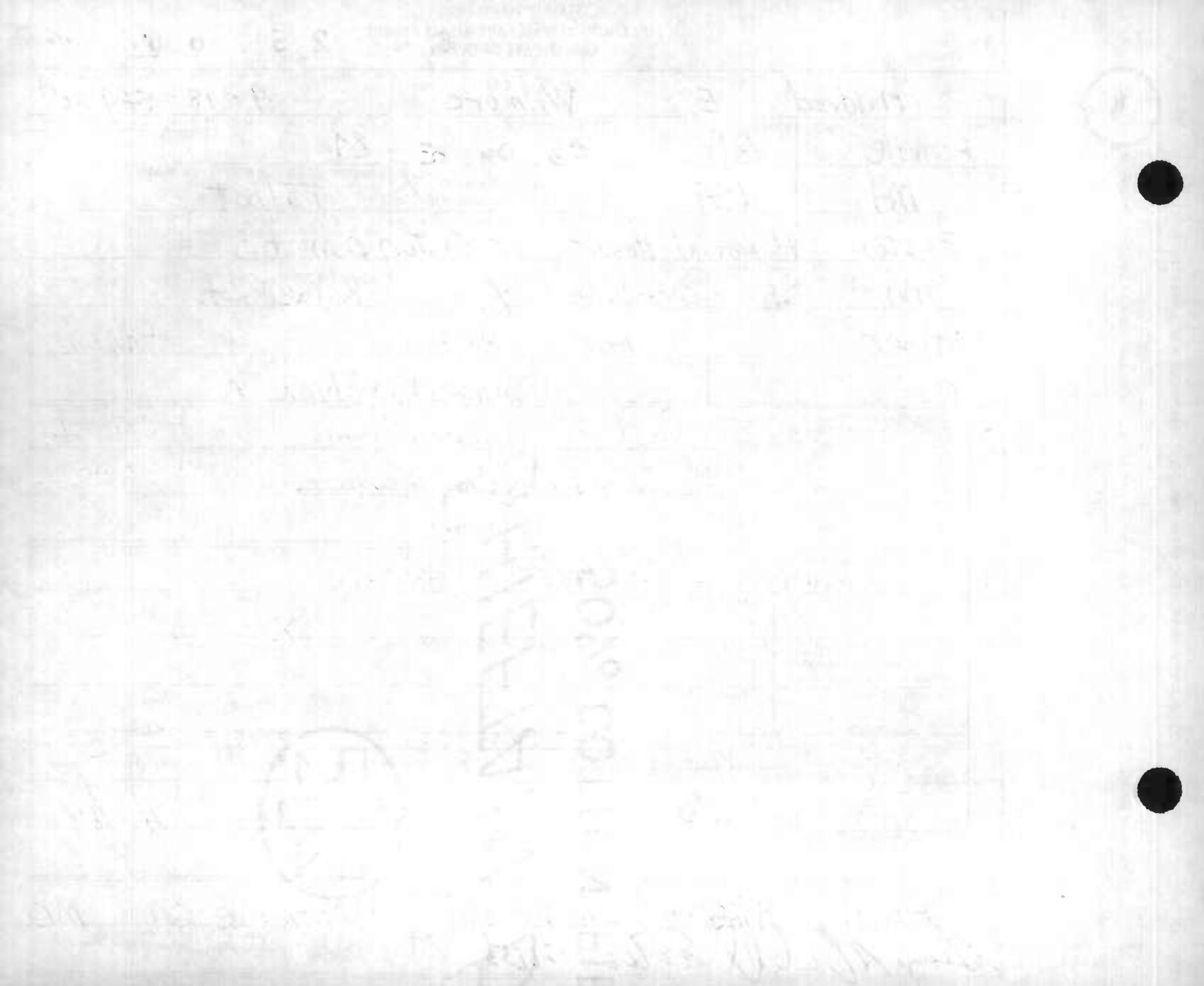


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please  
 remain by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached to use as the burial-travel permit. Then please return to the physician. Prior to burial, cremation, or removal, this should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 15, show any injury or other traumatic event, the medical examiner must be notified and the medical examiner must be furnished a copy of this certificate.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25168057 9/18/84			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Mildred			E			Wilmore			9-18-84			9:20 A			
35		SEX	4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
35		Female	B/K		06 06 83			81			YRS.				
35		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
35		Md	USA					Talbot			Easton				
35		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE				
35		Memorial Hospital at Easton Domestic									Md				
35		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE				
35		QA			Centerville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Kidwell St. 21617				
35		14. FATHER'S NAME FIRST MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
35		Walter		Wilmore			No						James E. Wilmore Sr.		
35		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Probable Hyperkalemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
35		DUE TO, OR AS A CONSEQUENCE OF (b) End Stage Renal Failure												Minutes	
35		DUE TO, OR AS A CONSEQUENCE OF (c) Nephroclerosis												4 P.M.	
35		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
35		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
35		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
35		21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
35		22a. I certify that (I) (this hospital) attended the deceased from 3/2/84 to 7/18/84, that (I) (we) last saw the deceased alive on 9/18/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
35		22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/18/84					
35		22e. PHYSICIAN'S NAME (TYPE OR PRINT)													
35		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/20/84			23c. NAME OF CEMETERY OR CREMATORIUM Chestfield			23d. LOCATION STREET CITY OR TOWN COUNTY STATE					
35		24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY FUNERAL DIRECTOR OCT 9			24c. REGISTRATION NO. 1000			24d. SIGNATURE John A. D'Amato					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25769		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Ruth ANNE Winter						9-23-84			4:30 PM					
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 26, 1893</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b>			10. CITY OR TOWN OF DEATH <b>Easton</b>				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Memorial</b>												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>TALBOT</b>			13c. CITY OR TOWN <b>EASTON</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>WM. HILL MANOR 21601</b>		
14. FATHER'S NAME <b>JOSEPH T. SALTHOUSE</b>						15. MOTHER'S MAIDEN NAME <b>SARAH KING</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>167-38-0010</b>			17. INFORMANT <b>HARRY J. BOERTZEL</b>			18. ADDRESS <b>STAR RT. ST. MICHAELS, Md.</b>			21663		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Stroke</b>												9 days		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b>915</b> CITY OR TOWN <b>Easton</b> COUNTY <b>MD</b> STATE <b>MD</b>								
22a. I certify that (I) (this hospital) attended the deceased from <b>9/23/84</b> to <b>9/23/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <b>9/24/84</b>		
22b. SIGNATURE <b>S. P. Carney</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>			22e. ADDRESS <b>Easton, Md. 21601</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>SEPT. 28, 1984</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>CHELTON HILLS ABBEY PHILA. PENNA.</b>			23d. LOCATION CITY OR TOWN <b>Chelton Hills</b> COUNTY <b>Philadelphia</b> STATE <b>PA</b>					
24. FUNERAL DIRECTOR NAME <b>Harrison Leonard Funeral Home St. Michaels, Md.</b>			ADDRESS <b>SEP 28, 1984</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 28, 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Murphy</b>					

